SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND

MANAGED CARE PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Revised August 1, 2017

CONTACT INFORMATION:

Administrative Office
Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5080
(800) 824-4427

MESSAGE FROM THE BOARD OF TRUSTEES

Dear Member:

This booklet describes the Managed Care Plan, made available through the Collective Bargaining Agreement in effect between your employer and your union.

Employer contributions for the Managed Care Plan described in the enrollment materials and this booklet are based on hours worked or paid for by active employees under collective bargaining agreements. These contributions finance this Plan on a month-to-month basis. Should contributions not provide sufficient funding to maintain benefits, the Trustees reserve the right to change the eligibility rules, reduce the benefits, or eliminate the Plan, in whole or in part, as may be required by the circumstances.

In the event that an insurance company or other benefit plan provider terminates its contract with the Trust Fund, every effort will be made to find a suitable replacement. In this instance you will be notified of the options available to you. Eligibility in the Managed Care Plan will not entitle you to eligibility in any other plan offered by the Trust Fund.

This is the Summary Plan Description and Plan Document for the Managed Care Plan. To obtain maximum benefits from the Plan, study this booklet carefully. Put this booklet in a safe and convenient place. We hope this booklet assists you in understanding your benefits and finding answers to your questions.

The only parties authorized to answer any questions concerning the Trust Fund and the Plan are the Board of Trustees and the Plan Administrator. No participating employer, employer association or labor organization nor any individual employed thereby has any such authority.

If you have any questions concerning the Managed Care Plan or you need assistance in securing your benefits, please call or write the Administrative Office at:

Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5080
(800) 824-4427

Sincerely,
BOARD OF TRUSTEES

AVISO A LOS PARTICPANTES

Este es un resumen que describe información importante acerca de sus beneficios del Plan de Salud y Bienestar. Si tiene dificultad en comprender cualquier parte de la información, favor de llamar a la oficina administrativa al (562) 463-5080 o (800) 824-4427 o visite la oficina que se encuentra ubicada en 1200 Wilshire Boulevard, Fifth Floor, Los Angeles, CA 90017-1906. El horario es de 8:30 a.m. a 4:30 p.m. de Lunes a Viernes. Una persona que habla español estará disponsible para ayudarle. Tambien para los que lo desean, estarán disponibles copias del Plan en español.

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ELIGIBILITY

Initial Eligibility

ACTIVE EMPLOYEES
You become eligible for benefits on the FIRST day of the SECOND calendar month following the calendar month in which you work, or are paid for, the Required Hours of employment for an employer, provided the required monthly contributions from your employer have been made. The required monthly contributions are those contributions necessary to cover the cost of the benefits for which you are eligible and are set by the Board of Trustees on an annual basis.

Contributions are due on all hours worked or paid for. Hours worked include both regular and overtime hours. Hours paid for include vacation, holiday, and sick leave, whether specifically included in your Collective Bargaining Agreement or not.

The term "Required Hours" means the number of hours worked or paid for in a calendar month which will provide a contribution from your employer as contained in your Collective Bargaining Agreement.

NOTE: Employees of employers newly signatory to this Plan will receive information regarding their initial eligibility at the time of their enrollment. Information about Plan choices and enrollment starts on page 30 of this Plan Booklet.

Eligibility Table
The table shown below can be used to determine when you become eligible***** and how you remain eligible while you continue to be employed by a contributing employer. **Upon cessation of employment, the eligibility rules apply similarly. An explanation of when your eligibility will terminate can be found in the section "When Your Eligibility Terminates" on page 6 of this Plan Booklet.**

If you work, or are paid, for the Required Hours and contributions are made for the payroll month of:	You will be eligible for benefits during the month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Under certain conditions, you may choose to continue your coverage by self-payment. For information on "COBRA Continuation Coverage," please see pages 7 through 15 of this Plan Booklet.

Newly Hired Employees:
If you are a newly hired employee of an existing employer in this Plan, your employer may make the equivalent of two monthly employer contribution payments to the Trust Fund in order for you to obtain immediate eligibility, i.e., the initial two-month eligibility period under the table above will not apply to you. However, there must be a signed collective bargaining agreement or election agreement on file with the Administrative Office providing for this eligibility rule before any advance payment of employer contributions can be accepted. For additional information have your employer call the Administrative Office.

New Employers:
Effective January 1, 2014, employees of new employers who are on the employer's payroll when participation begins will be provided with eligibility in the month immediately following the first work month for which the employer pays the required contributions. (Example: employment and contributions for January will create eligibility in February.) This special rule is also applicable to the initial group of employees if they remain in employment for the next following month and the employer pays the required contributions. Thereafter, the usual two-month qualifying rule will apply.

If the employer withdraws from participation within five years from the initial month of employer contributions, the employer will be obligated to the Fund in an amount equal to one month of contributions multiplied by the initial number of employees that were provided with immediate eligibility (calculated at the rate that was then in effect). However, if the employer does not withdraw from participation for five years, this obligation will be waived.

Any new employee of the employer added after the initial work month will be eligible for benefits in accordance with the usual eligibility rules.

DEPENDENTS
The Collective Bargaining Agreement between your employer and your union may provide for health and welfare coverage for you, your spouse, and your dependent children, or it may provide coverage for you, the employee and your dependent children if your employer is a "large employer" under the Patient Protection and Affordable Care Act. You must apply for enrollment of your dependent children and spouse, as applicable, and the required contributions for their coverage must be paid by your employer. In some instances, the Collective Bargaining Agreement may require deductions from your payroll check to pay a portion of the contribution for dependent coverage.

Your dependents become eligible for benefits at the same time your benefits begin, provided your dependents are enrolled and the required contributions have been made for dependent coverage. Dependents acquired after you are eligible become eligible for benefits on the following dates:

Dependent	Eligibility Begins
Spouses	On the first day of the calendar month following the date of marriage
Children In the case of birth, adoption, or placement for adoption All other dependent children (as defined on page 4 below)	 On the date of birth, adoption, or placement for adoption On the first day of the calendar month following the month in which they become a dependent

Dependents must be enrolled within 30 days of becoming eligible. An Enrollment and Plan Selection Form is available from the Administrative Office.

If you do not enroll your dependents when you first become eligible, and the HIPAA Special Enrollment Rights do not apply, your dependents will not be allowed to enroll until the next open enrollment period. At this time, the required enrollment materials must be completed, and upon approval, the contributions must be paid for dependent coverage. An explanation of HIPAA's Special Enrollment Rights can be found on page 16 of this Plan Booklet. Even under these Special Enrollment Rights, dependents are not eligible unless the required enrollment materials are submitted and the required contributions are made.

DEFINITION OF ELIGIBLE DEPENDENTS

PLEASE NOTE: Your dependents are eligible for coverage only if you and your dependents have enrolled in the Plan and the required contributions have been made.

Dependents eligible for enrollment in the Plan are:

1. The employee's lawfully married spouse, as defined below;

2. The employee's domestic partner, as defined below; and

3. The employee's children, as defined below, who are under age 26.

Spouse

For all purposes under the Plan, the term "spouse" shall mean any individual who is lawfully married under any state law authorizing such a marriage.

Domestic Partner

To qualify as an employee's domestic partner, the following criteria must be met by the employee and domestic partner:

1. Both persons must file a Declaration of Domestic Partnership with the Secretary of the State of California and provide a copy to the Administrative Office;*

2. Both persons must have a common residence;

3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated;

4. The two persons must not be related by blood in any way that would prevent them from being married to each other;

5. Both persons are at least 18 years old;

6. Both persons must be members of the same sex, or, if opposite sex, one or more persons must be over age 62; and

7. Both persons must be capable of consenting to the domestic partnership.

*For those employees who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in items 2-7 above is met. The Administrative Office will provide employees with the Affidavit upon request.

In addition to the above requirements, both the employee and domestic partner agree to inform the Administrative Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner.

The election by an employee to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the employee. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The employee's employer is then responsible for including the imputed income on the employee's wages and withholding any FICA, FUTA, Medicare and Federal income taxes, as applicable.

Dependent Children
Dependent coverage must be continuous. (But see special enrollment provisions and waiver provisions on pages 16 to 20.)

Dependent Children shall include only the following:

1. Employee's natural children;

2. Legally adopted children or children lawfully placed with the employee for legal adoption from the date of placement;

3. Stepchildren (children of a lawfully married spouse);

4. Foster children;

5. Children for whom the employee is the court appointed legal guardian, and who permanently reside in the employee's household;

6. Any children who are "alternate recipients" under a Qualified Medical Child Support Order (if the children are not already covered by the Plan).*

In addition, a dependent child whose coverage would otherwise terminate due to the age limits of the Plan may continue to be eligible if they are disabled and incapable of self-sustaining support and chiefly dependent on the employee for principal support and maintenance as a result of a mental or physical disability that occurred prior to reaching the age limit. A statement signed by the dependent child's doctor verifying the disability must be submitted within 31 days of attainment of the age limit, and periodically resubmitted to the Administrative Office upon request. This extension will continue until the earliest of (1) the date he/she ceases to be eligible for reasons other than age, (2) the date he/she ceases to be incapacitated, (3) the date he/she ceases to be chiefly dependent on the employee for principal support and maintenance, or (4) the 31st day after the Fund requests additional proof of his/her incapacity and such proof is not furnished.

A person (adult or child) may be living with you and totally dependent upon you for support. However, the person is not recognized as a dependent for coverage under this Plan unless they meet the requirements set forth above.

Other children including, but not limited to, nieces, nephews, grandchildren, brothers and sisters, etc., are not considered dependents of the employee unless they permanently reside in the employee's household and the employee has been designated as the court appointed legal guardian and proof of legal guardianship is submitted to the Administrative Office for review.

The Administrative Office may require an employee to verify dependent eligibility by submitting birth certificates, adoption papers, marriage certificate and/or any other form of proof of dependent status it deems necessary.

The term "dependent" will not include any person who is in full-time military service.

*****A Medical Child Support Order will be recognized by the Plan and your dependent(s) will be covered so long as the order or notice is qualified and in conformance with the written policies and procedures adopted by the Plan in accordance with the Omnibus Budget Reconciliation Act of 1993 (as amended by the Personal Responsibility and Work Opportunity Act of 1996 and the Child Support Performance and Incentive Act of 1998). A Medical Child Support Order (MCSO) is a court order, judgment, or decree under state domestic relations law (or order or notice issued through an administrative process established under state law which has the force and effect of law in that state or a National Medical Support Notice) requiring that health benefit coverage be provided to a child under a parent's health plan. However, a dependent will be eligible for coverage only if his full name, date of birth, and relationship to the employee has been registered with the Administrative Office by filing an Enrollment and Plan Selection Form. A copy of the written policies and procedures is available from the Administrative Office at no charge. Additional contributions will be necessary if you do not currently have dependent coverage under the Trust Fund, and you may not object to any applicable payroll deduction relative to dependent coverage.

How Your Eligibility Continues

After your eligibility is established, you and your dependents remain eligible as long as you continue to work, or are paid for, the Required Hours of employment each month, and your employer makes the required contribution. (See the "Initial Eligibility" section on page 1 of this Plan Booklet.)

When Your Eligibility Terminates

Unless coverage is continued under COBRA (see page 7 of this Plan Booklet), your eligibility for benefits terminates on the LAST day of the second calendar month following the month in which you last worked, or were paid for, the Required Hours (and the required contributions were made) as shown below.

If you last work, or are paid, for the Required Hours and contributions are made for the payroll month of:	Your eligibility for benefits will terminate on the last day of:
January	March
February	April
March	May

Eligibility for you and your dependents will terminate on the final day of the month in which you last worked, or were paid for, the Required Hours if your employer obtains (or will obtain) alternate health and welfare coverage outside of the Trust Fund, or withdraws from the Trust Fund for any reason (other than a plant closure or bankruptcy), including its failure to have a signed Collective Bargaining Agreement with the Union; and no lag month eligibility is available to you (including employees of new employers that came into the Plan under the immediate eligibility rules described above). For example, if your last contribution payment to the Trust Fund is based on the Required Hours worked for June, your coverage will terminate on June 30.

In addition to the above, your eligibility and your dependents' eligibility for benefits will terminate on the date on which you enter the uniformed services of the United States, except that you may elect to continue coverage for you (and your eligible dependents) during your period of service as further explained under the provisions on Health Continuation Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA). (See page 15 of this Plan Booklet.)

Reinstatement of Eligibility
If you return to work for an employer within 12 months after your coverage terminated, you will regain eligibility on the first day of the second calendar month following the calendar month in which you work, or are paid for, the Required Hours of employment, provided the required contribution is made by your employer, as shown below.

Month Coverage Terminated	Return to Work (and work, or are paid for, the Required Hours and contributions are made for the month of):	You will be eligible for benefits during the month of:
April	September	November
May	October	December
June	November	January

If you return to work for an employer later than 12 months after your coverage terminated, the normal initial eligibility rules will apply (i.e., you will be eligible for coverage on the first day of the second calendar month following the calendar month in which you work, or are paid for, the Required Hours of employment, and the required contributions are made by your employer for two consecutive months.

HEALTH CONTINUATION COVERAGE UNDER COBRA

You and your eligible dependents have the option to elect COBRA continuation coverage when your health coverage would otherwise terminate due to certain qualifying events. COBRA continuation coverage requires payments by you or your eligible dependents (or any other third party). Below, in summary form, is an explanation of the COBRA continuation coverage rules. Contact the Administrative Office for further information.

Eligibility and Coverage Periods

PARTICIPANT
If you are:

1. AN EMPLOYEE participating in the Managed Care Plan; and

2. you lose your health coverage because of one of the following qualifying events:

    a. a reduction in hours**; or
    b. termination of employment (other than for reasons of gross misconduct),

you are a Qualified Beneficiary*** and have the right to elect COBRA continuation coverage for up to 18 months from the date of loss of coverage if you elect to continue the coverage during the election period. A reduction of hours followed by a termination of employment does not extend the 18-month period for you or your eligible dependents.

SPOUSE
If you are:

1. THE SPOUSE OF AN EMPLOYEE participating in the Managed Care Plan; and

2. you are also covered by the Plan as a dependent; and

3. you lose your health coverage because of one of the following qualifying events:

    a. a reduction of your spouse's hours** or termination of your spouse's employment (other than for reasons of gross misconduct);
    b. the death of your spouse; or
    c. a divorce or legal separation from your spouse,

you are a Qualified Beneficiary*** and have the right to elect COBRA continuation coverage if you elect to continue the coverage during the election period. The maximum continuation coverage period is 18 months from the date of the loss of coverage in the event of a reduction of hours** or termination of employment. In the event of your spouse's death or your divorce or legal separation from your spouse, you have the right to elect COBRA continuation coverage for up to 36 months from the original date of the loss of coverage. If your spouse became entitled to Medicare (Part A or B) prior to losing eligibility because of a reduction in hours or termination of employment (other than for reasons of gross misconduct), you may continue your coverage for the longer of:

1. 18 months (or 29 months in the case of disability extension) from the date eligibility was terminated; or

2. 36 months from the date of your spouse's entitlement to Medicare (actual enrollment in Part A or B).

DEPENDENT
If you are:

1. THE DEPENDENT CHILD OF AN EMPLOYEE participating in the Managed Care Plan; and

2. you are also covered by the Plan* as a dependent; and

3. you lose your health coverage because of one of the following qualifying events:

    a. a reduction in hours** or termination of employment of the employee parent (other than for reasons of gross misconduct);
    b. the death of the employee parent;
    c. the employee parent's divorce or legal separation; or
    d. loss of dependent status under the Plan rules,

you are a Qualified Beneficiary*** and have the right to elect COBRA continuation coverage if you elect to continue the coverage during the election period. The maximum continuation coverage

period is 18 months from the date of the loss of coverage in the event of a reduction of hours or termination of employment by the employee parent. In the event of your employee parent's death, employee parent's divorce or legal separation or your loss of dependent status, you have the right to elect COBRA continuation coverage for up to 36 months from the original date of the loss of coverage. If your employee parent became entitled to Medicare (Part A or B) prior to losing eligibility because of a reduction in hours or termination of employment (other than for reasons of gross misconduct), you may continue your coverage for the longer of:

1. 18 months (or 29 months in the case of a disability extension) from the date eligibility was terminated; or

2. 36 months from the date employee parent's entitlement to Medicare (actual enrollment in part A or B).

*If you become a dependent child of an employee by reason of birth, adoption, or placement for adoption during a period when the employee is receiving COBRA continuation coverage, you also have the right to elect COBRA coverage. For purposes of determining the extension period, the qualifying event for this child is the same qualifying event as the employee parent.

**A reduction in hours due to a leave under the Family and Medical Leave Act (FMLA) does not constitute a qualifying event under COBRA. If the participant/employee, however, does not return to employment with his employer at the end of the FMLA leave, a COBRA qualifying event will occur on the date the employee would otherwise lose health coverage following the end of the FMLA leave. A reduction of hours due to any other leave of absence, strike, walkout, or layoff will be considered a qualifying event.

***Only you or your spouse or dependents who are covered under the Plan the day before a qualifying event (and a dependent child described under the * above) are considered Qualified Beneficiaries. Other dependents added during the period of COBRA coverage based on the Trust Fund's annual open enrollment period or the HIPAA Special Open Enrollment Rights do not become Qualified Beneficiaries. If a second qualifying event occurs, these dependents are not entitled to extend their COBRA coverage to 29 or 36 months as would a Qualified Beneficiary.

NOTE: A domestic partner in the Managed Care Plan is not a Qualified Beneficiary and does not have the right to elect COBRA continuation coverage. Nevertheless, if you are a domestic partner of an employee and you lose coverage as a result of the termination of your domestic partnership or any other COBRA qualifying event discussed in this section under "Spouse," please contact the Administrative Office for information regarding the continuation of your coverage.

Second Qualifying Events and COBRA Maximum Continuation Period

A second qualifying event, such as a member entitlement to Medicare or a member death, during the initial period of coverage may allow a spouse or dependent who is a Qualified Beneficiary to receive up to 36 months of COBRA coverage, even though the initial coverage was for 18 months. However, the maximum COBRA continuation period is 36 months, even if multiple qualifying events occur.

It is the responsibility of you (or your dependent(s)) to inform the Administrative Office of a second qualifying event within 60 days from the date on which you (or your dependent(s)) lose (or would lose) coverage under the Fund as a result of the second qualifying event.

Obligation to Notify the Fund

It is the responsibility of you (or your dependent(s)) to inform the Administrative Office of a divorce, legal separation, or loss of dependent status within 60 days of the later of the date of (1) the loss of coverage, or (2) the date on which you (and/or your dependent(s)) are informed through the furnishing of the Summary Plan Description and Plan Document or the general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office. It is the responsibility of your Employer to inform the Administrative Office of an employee's death or entitlement to Medicare within 60 days of these qualifying events. However, a family member should also contact the Administrative Office if these events occur. It is the responsibility of the Administrative Office to determine when there has been an employee reduction in hours or termination of employment within 60 days of these qualifying events.

Any notice that you (or your dependent(s)) are required to make under the COBRA section of this Plan Booklet must be in writing and sent to the Administrative Office at the address listed in the COBRA "Change of Address" section on page 15 of this Plan Booklet The notice(s) must be furnished within the applicable time period defined above for qualifying events and below for Social Security Administration (SSA) disability determinations and contain:

1. The name of the Plan;

2. Your name and the name(s) of your dependent(s);

3. The qualifying event(s) (or other event such as a SSA disability award or recovery from a SSA disability);

4. The date(s) of the qualifying event; and

5. Your (and/or your dependent(s)') address(es).

Any notice that your Employer is required to make under the COBRA section of this Plan Booklet must be in writing and sent to the Administrative Office at the address listed in the COBRA

"Change of Address" section on page 15 of this Plan Booklet. The notice must be furnished within the applicable COBRA time period and contain:

1. The name of the Plan;

2. The name and address of the employee;

3. The name(s) of the dependent(s) (if known);

4. The qualifying event; and

5. The date of the qualifying event.

Notices of a qualifying event (or any extension thereof due to a second qualifying event, or a Social Security Administration (SSA) disability determination, and if SSA determines you have recovered from the disability) may be made by you, your dependent(s), or a representative acting on behalf of you (and/or your dependent(s)).

COBRA Notices

When the Administrative Office has received information or determines that a qualifying event has occurred, you and/or your spouse/dependent will be sent a COBRA notice explaining their rights to COBRA continuation coverage along with a COBRA continuation coverage election form. This COBRA notice will provide information on the coverages available and the applicable costs. If you desire COBRA continuation coverage, you are required to send the COBRA election form to the Administrative Office within 60 days of the later of (1) the date you receive the COBRA notice and election form, or (2) the date you would otherwise lose coverage. If you waive COBRA coverage during this 60-day period, you may revoke your waiver at any time during the same 60-day period.

If you choose to elect COBRA continuation coverage, the Fund will provide you with the same health care coverage that you had as an active employee or the dependent of an active employee. Life insurance and accidental death and dismemberment benefits are not provided. You will be required to elect all of the health care coverages you had prior to your qualifying event. You may not, for example, choose medical coverage only, if your prior coverage was medical and dental. If you move out of the area of a region-specific HMO medical or prepaid dental plan, the Trust Fund will offer its corresponding Medical and Dental Indemnity Plan coverages, if any, with the applicable reimbursement limitations.

You do not have to show that you are insurable to choose COBRA continuation coverage. You will have to pay for COBRA continuation coverage. You or your dependents (or any other third party) will have 45 days to make the initial payment after the date you elect the coverage (including any retroactive amount that may be due). Thereafter, monthly payments are due by the first of each month until you are no longer eligible for COBRA continuation coverage. Coverage will be cancelled if no payment is sent to the Fund within 31 days of the due date. The Administrative Office will not send monthly bills or notices. It is your responsibility to submit payment when due. However, if you make an insignificant underpayment in the amount of the monthly COBRA

premium, you will be notified by the Administrative Office of the deficiency. You must pay the amount of the underpayment within 30 days of the original due date or your COBRA coverage will be cancelled. An insignificant underpayment is defined as less than $50.00 under the total COBRA premium (or 10% of the amount due if the COBRA premium is less than $50.00).

When the Administrative Office has reviewed information under the notice procedures specified above and determines that a qualifying event (legal separation, divorce, or loss of dependent status), a second qualifying event, or a determination of disability by the Social Security Administration regarding you (and/or your dependent(s)) has not occurred, the Administrative Office will furnish you (and/or your dependent(s)) with an explanation as to why you (and/or your dependent(s)) are not entitled to COBRA coverage (or an extension thereof) no later than 14 days after the receipt of the notice you (and/or your dependent(s)) provided.

If you become eligible for Trade Adjustment Assistance (TAA) pursuant to the Trade Adjustment Assistance Act of 2002 or are an eligible alternative TAA recipient under the Act or any later law or Act, and you did not elect COBRA continuation coverage during the 60-day election period that was a direct consequence of the TAA-related loss of coverage, you may elect COBRA coverage (for you and your eligible dependents) during a 60-day period that begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided such election is made not later than six months after the date of the TAA-related loss of coverage. Any COBRA coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage originally lapsed.

Termination of COBRA Coverage

COBRA continuation coverage will be terminated for any of the following reasons:

1. You (or your spouse or dependent or other third party) fail to pay the premiums for your continuation coverage in a timely fashion as defined in the preceding section;

2. You (or your spouse or dependent) first become covered under another group health plan as an employee or as a dependent after the date of your COBRA election;

3. The Managed Care Plan is terminated, except that if you or your eligible dependents are on COBRA and your present/former employer withdraws from the Plan for any reason, you and your eligible dependents will be entitled to continued coverage under this Plan unless your employer makes available either existing or new health coverage to a class of the employer's employees formerly covered under this Plan;

4. You (or your spouse or dependents, if applicable) first become entitled to Medicare (actual enrollment in Part A or B) after the date of the COBRA election (however, non- employee Qualified Beneficiaries who are covered at the time that you are entitled to Medicare may elect to continue their COBRA for up to a total of 36 months);

5. You (or your spouse or dependents, if applicable) have extended continuation coverage due to a disability and then are determined by Social Security Administration to be no longer disabled;

6. The maximum required COBRA continuation period expires; or

7. For cause (such as a fraudulent claim submission) that would result in the termination of coverage for non-COBRA participants.

If your (and/or your dependent(s)') COBRA coverage is subject to early termination, the Administrative Office will furnish you (and/or your dependent(s)) with a notice as soon as practicable providing (1) the reason that the COBRA coverage has terminated earlier than the end of the maximum COBRA period applicable to the qualifying event, (2) the date of termination, and (3) any rights you (and/or your dependent(s)) may have under the Fund or under applicable law to elect an alternative group or individual coverage (see "Conversion Coverage" on page 14).

Special Extension of COBRA Continuation Coverage Based on Disability as Determined by the Social Security Administration

A special COBRA Extension applies in the event that you (or your dependent) apply for social security disability benefits and if social security determines that you (or your dependent) were disabled as of the time of, or within 60 days of, your reduction in hours or termination of employment (or in the case of a child born to or adopted by you, or placed for adoption with you during a COBRA coverage period, during the first 60 days after the child's birth, adoption, or placement for adoption) and the disability lasts at least until the end of the 18-month initial period of continuation coverage. You (or your dependents) will be entitled to an additional 11 months of COBRA continuation coverage beyond the initial 18-month entitlement for a total of 29 months of COBRA continuation coverage. If you or the disabled dependent have non- disabled family members who were covered under COBRA for the first 18 months, they also will be entitled to the additional 11 months if their COBRA premiums are paid. The premium charged for this additional 11 months of coverage will be 150% of the COBRA rate set annually by the Board of Trustees (see below). However, if a disabled dependent experiences a second qualifying event within the original 18 month period, COBRA coverage may be extended to 36 months and the premium charged will be 102% for the entire extended period. If the second qualifying event occurs after the original 18-month period the premium charged will be 150% through the extension period. Even if a disabled employee or dependent does not elect or pay for COBRA coverage, the non-disabled members who elected COBRA are entitled to the additional 11 months of coverage. The premium charged in this case will be 102%.

You (or your dependent(s) or other representative acting on your behalf) are responsible for notifying the Administrative Office within 60 days after the later of the date of the disability determination by the SSA, the date on which you (or your dependent(s)) lose (or would lose) coverage under the Plan as a result of a qualifying event; or the date on which you (or your dependent(s)) are informed through the furnishing of the Summary Plan Description and Plan Document or the general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office.

You (or your dependent(s) or other representative acting on your behalf) are also obligated to notify the Administrative Office within 30 days after the later of the date of the final determination by the SSA under Title II or XVI of the Social Security Act, that you (or your dependent(s)) are

no longer disabled; or the date on which you (or your dependent(s)) are informed through the Summary Plan Description and Plan Document or general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office. Upon such determination, COBRA continuation coverage will be terminated for the disabled individual (and any non-disabled family members) if the initial 18 months of COBRA continuation coverage has been exceeded.

The COBRA termination will occur 30 days after the month in which the SSA determined that you (or your dependent(s)) were no longer totally disabled or earlier if the SSA determined you (or your dependent(s)) recovered from the disability within the initial 18-month period. Please note that a disabled individual's COBRA coverage terminates, even in disability situations, when the eligible individual's Medicare coverage begins.

COBRA Payment Rates

COBRA continuation coverage payment rates are set annually by the Board of Trustees. Information on current rates is available from the Administrative Office.

Special Tax Credit for TAA Individuals

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for Trade Adjustment Assistance (TAA). Under those tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for COBRA coverage. Beginning May 1, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) increased the tax credit or advance payment to 80% of eligible individuals' premiums paid for COBRA coverage through December 31, 2010 (unless extended by Congress). ARRA also extended the period of the tax credit for TAA-eligible individuals and for those receiving benefits from the Pension Benefit Guaranty Corporation under certain circumstances, as well as expanded the availability of the tax credit to qualified family members of TAA-eligible individuals and PBGC recipients. Additionally, ARRA provided for an extension of the COBRA coverage period under certain circumstances. The Omnibus Trade Act of 2010 and the Trade Adjustment Assistance Extension Act of 2011 generally extended the tax credit (at 72.5% of premiums for the months beginning after February 12, 2011) and the COBRA coverage period through January 1, 2014. Under the Trade Preferences Extension Act of 2015, the tax credit for eligible individuals was reinstated for months beginning January 1, 2014 through December 2019. If you have any questions about the tax provisions, or if you want to know if you are eligible for this program, you may call the IRS at (800) 829-1040. More information about the TAA Program and the extension of the tax credit described above is available at **www.irs.gov/hctc**.

Conversion Coverage

At the end of the applicable COBRA continuation coverage period, you will be allowed to enroll in whatever individual conversion health plan is available under the Fund rules. Currently, there are no conversion programs for the Indemnity Medical, Dental, Prescription Drug, and Vision Benefit programs. The prepaid plans, however, continue to offer conversion privileges. If your

spouse has other coverage or if you believe you (and/or your dependent(s)) are eligible for state or federal assistance, you may also want to contact these plans(s) and agency(ies) as well.

Termination of COBRA by an HMO

If you or your spouse or dependent have COBRA continuation coverage through one of the Fund's HMO programs and you are terminated from the program because you move out of the HMO's service area before the applicable COBRA period expires and the Fund does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Indemnity Medical and/or Dental Plan until the expiration of the applicable COBRA period, so long as payment of COBRA premiums are continuous and timely and the other COBRA requirements are met for the continuation of health coverage. Please call the Administrative Office for additional details.

Change of Address

It is important that you (or your spouse or dependent or representative acting on your behalf) notify the Fund in writing if you change your address. This information should be sent to:

Southern California Lumber Industry Welfare Fund
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

Compliance with Law

The Board of Trustees has adopted procedures for complying with COBRA based on their interpretation of the law. The Board reserves the right to make any changes it deems appropriate or as required by law. Any oversights and/or omissions will be interpreted in accordance with the applicable law and corresponding regulations.

HEALTH CARE CONTINUATION COVERAGE UNDER USERRA

You and your eligible dependents have the option to elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from your position of employment by reason of service in the uniformed services. The maximum period of coverage for you and your dependents is the lesser of the 24-month period beginning on the date on which your absence begins (or you lose coverage under the Plan, whichever is later) or the day after the date on which you fail to apply for or return to employment with your last employer as provided under USERRA. The premium charged for such coverage will be the applicable premium and must be paid on a monthly basis in a timely manner. When you return to employment with your employer, there will be no waiting period in connection with the reinstatement of your (and your eligible dependents', if applicable) coverage. However, no

coverage will be provided for those illnesses or injuries, which are incurred in or aggravated during the performance of service in the uniformed services as determined by the Department of Veterans Affairs.

Uniformed services means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the Commissioned Corps of the Public Health Service, persons appointed for service in the National Disaster Medical System, and any other category of persons designated by the President of the United States in time of war or emergency.

If you or your spouse or dependent have USERRA continuation coverage through one of the Fund's HMO programs and you are terminated from the program because you move out of the HMO's service area before the applicable USERRA period expires and the Fund does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Indemnity Medical and/or Dental Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage. Please call the Administrative Office for additional details.

Coverage under USERRA is considered alternative coverage. Therefore, the USERRA and COBRA continuation periods run concurrently. Please call the Administrative Office for further information.

SPECIAL ENROLLMENT RIGHTS UNDER HIPAA

You may decline initial participation or coverage under this Trust Fund for you and/or your dependents as follows:

You and/or Your Existing Dependents

If you declined initial* coverage for you and/or your dependent(s) at the time you were initially offered coverage through this Fund because you and/or your dependent(s) had other health coverage under another health plan or insurance and there is a loss of your and/or your dependent(s) eligibility under that coverage, HIPAA requires that the Trust Fund make certain special enrollment rights available to you and/or your dependent(s) if:

1. You and/or your dependent(s) are otherwise eligible to enroll under the terms of the Managed Care Plan and the requested benefit option; and

2. You request enrollment for you and/or your dependent(s) no later than 30 days after your and/or your dependent(s) loss of coverage in the other health plan or insurance (no later than 60 days after you and/or your dependent(s)' loss of coverage under Medicaid or a State Child Health Insurance Plan (CHIP)); and

3. Your employer makes the required contributions.

Events that constitute a loss of your and/or your dependent(s) eligibility under other health coverage include termination of employment, reduction in the number of hours of employment, cessation of dependent status (if otherwise eligible under this Plan), loss of HMO coverage due to you and/or your dependent(s) no longer residing, living, or working in the service area of the HMO when no other benefit package is available to you and/or your dependent(s) under the other health coverage, cessation of health coverage to a class of similarly situated individuals of which you and/or your dependent(s) are a member, termination of employer contributions that were contributing to the other health coverage for you and/or your dependent(s) even if you continue the coverage by paying the premiums previously paid by the employer or loss of coverage under Medicaid or CHIP (see also the COBRA discussion below).

If the conditions set out in (1), (2) and (3) above are met, coverage in the Managed Care Plan will begin no later than the first day of the first calendar month beginning after the date the Plan receives your request for special enrollment and the Plan has received enrollment materials that are substantially complete and the required contributions are made by your employer.

*The special HIPAA enrollment rules as set forth above also apply if you initially declined health and welfare coverage under the Plan for your dependent(s) for another reason but subsequently obtain other health coverage for them, decline coverage under this Plan again during an open enrollment period for that reason, and then lose that other health coverage. If the special enrollment rules do not apply to you and/or your dependent(s), you can still enroll you and/or your dependent(s) during the Managed Care Plan's annual open enrollment from November 1 to November 30 each year if you and/or your dependent(s) are otherwise eligible, you complete the required enrollment materials, and your employer makes the required contributions. The Plan's two-month waiting period will apply in this instance.

New Dependents

HIPAA also requires the Trust Fund to make certain special enrollment rights available to a new dependent(s) added through marriage, birth, adoption, or placement for adoption. At the same time, you may add you and/or your existing dependents who are not currently in the Fund, but only if:

1. You and/or your new dependent(s) and existing dependent(s), if applicable, are otherwise eligible to enroll under the terms of the Managed Care Plan and the requested benefit option; and

2. You request enrollment of you and/or your dependent(s) no later than 30 days after the date that the new dependent(s) becomes a dependent(s) by marriage, birth, adoption or placement for adoption; or no later than 60 days after the new dependent(s)' loss of coverage under Medicaid or CHIP; and

3. Your employer has made the required contributions.

If the conditions set out in (1), (2) and (3) above are met, coverage in the Managed Care Plan will begin in the case of marriage, no later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment and the Plan has received enrollment materials that are substantially complete. In the case of birth, adoption, or placement for adoption,

coverage will begin on the date of birth, adoption, or placement for adoption, respectively; however, you will need to complete the Plan's enrollment materials as soon as possible but no later than the 30 days following the initial 30-day notice period (or 60- day notice period, if applicable).

The HIPAA special enrollment rules as set forth above also apply if you initially declined health and welfare coverage under this Plan for your dependent(s) for another reason but subsequently obtain other health coverage for them, decline coverage under this Plan again during an open enrollment period for that reason, and then lose that other health coverage. If the special enrollment rules do not apply to you and/or your dependent(s), you can still enroll you and/or your dependent(s), however, during the Managed Care Plan's annual open enrollment period from November 1 to November 30 each year, if you and/or your dependent(s) are otherwise eligible, you complete the required enrollment materials, and your employer makes the required contributions. The Plan's two-month waiting period will apply in this instance.

Miscellaneous

Special rules apply when your and/or your dependent(s)' health coverage is COBRA continuation coverage. You and/or your dependent(s) do not have to elect COBRA continuation coverage under the other health plan or insurance in order to have the right to special enrollment under this Plan. However, when the other health plan or insurance coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA coverage. Special enrollment under HIPAA also applies to your dependent(s) if you are receiving COBRA continuation coverage under this Managed Care Plan and you request to add your dependent(s) who has been receiving health coverage elsewhere and has lost eligibility for that coverage.

If your existing dependent(s) or new dependent(s) can be added under HIPAA's special enrollment rules, at the time the dependent(s) is enrolled**,** you may enroll in another benefit option under the Managed Care Plan, i.e., if you are enrolled in the indemnity plan you may change to one of the Fund's HMO**'**s or vice versa. Please note, however, this change is subject to the availability of the benefit option. For example, an HMO may require that you and/or your dependent(s) reside in the HMO's service area.

***Under no circumstances, will this Fund offer dependent coverage only. The employee must be a participant in the Managed Care Plan before his dependents are eligible for coverage. In addition, all of your dependent children must be added at the same time, i.e., coverage for only one dependent child is not available if you have more than one.**

Any request for special enrollment of you and/or your dependent(s) should be made in writing and addressed to:

Southern California Lumber Industry Welfare Fund
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

You may also call the Trust Fund's Administrative Office at (562) 463-5080 or (800) 824-4427.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 ("FMLA") allows eligible employees of covered employers to take job-protected, unpaid leave for up to 12 weeks a year for the birth and/or care of a newborn, adopted, or foster child; to care for a family member with a serious health condition; when the employee is unable to work due to a serious health condition; or for certain "qualifying exigencies" or "military caregiver leave" available to eligible employees with family members serving in the military. During FMLA leave, the employee's health plan benefits must be continued and the employer must continue to make contributions on behalf of the employee to the Fund as though the employee had been continuously employed.

Compliance with the FMLA is the responsibility of the employer and the Plan does not determine whether an employee is eligible for FMLA leave. There are many complex rules that affect, for example, which employers are required to comply, how eligibility is determined, how leave should be calculated, and the protections available for covered employees. Any disputes regarding entitlement to FMLA leave must be resolved with your employer. If your employer approves FMLA leave for you, you (and your covered dependents) will continue to be covered under this Plan, while you are absent from work on FMLA eave, as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage, provided you were covered under the Plan when the leave began and your employer continues to make the required contributions.

WAIVER AND RE-ENROLLMENT RIGHTS FOR EMPLOYEES WITH COVERAGE UNDER THIS PLAN*

If you and/or your dependent(s) already have coverage under the Managed Care Plan, you may waive your (and your dependent(s)) coverage, if you (and your dependent(s)) acquire (or have) other group health coverage. Coverage will terminate in accordance with the Managed Care Plan's lag month rules on the first of the applicable month.

A request for waiver must be in writing and you must enclose with your request proof of other group health coverage. It should be sent to the Administrative Office at the following address:

Southern California Lumber Industry Welfare Fund
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

Other group health coverage does not include, for example, Medicare, Medicaid (or other similar state or federal coverage), individual coverage, or other health coverage offered by an employee's employer.

If you (and your dependent(s)) should then lose this other group health coverage, you (and your dependent(s)) may re-enroll in the Managed Care Plan, if written notice is received by the Administrative Office within 30 days of the loss of coverage and you (and your dependent(s)) are

eligible for coverage under the Managed Care Plan and have completed the required enrollment materials. Coverage will begin the first of the next month if the applicable employer contributions are made and the notification is received by the 15th of the prior month.

Events that constitute a loss of group health coverage are outlined under the prior section entitled "Special Enrollment Rights." However, you (and your dependent(s)) must exhaust any COBRA coverage offered by the other group health coverage before you (and your dependent(s)) can re-enroll in the Managed Care Plan.

If you do not comply with the time frames for re-enrollment mentioned above (or you waive coverage for your dependent(s)) for any other reason than your dependent has other group health coverage, you will not be allowed to re-enroll in the Managed Care Plan until the next open enrollment period. You (and your dependent(s)) must also be otherwise eligible for coverage under the Managed Care Plan, have completed the required enrollment materials and your employer must make the required contributions.

If you (and your dependent(s)) obtain other group health coverage again, you (and your dependent(s)) will not be able to waive coverage under the Managed Care Plan until the next Open Enrollment Period (unless HIPAA's special enrollment rules apply). Any subsequent requests for waiver and re-enrollment for loss of group health coverage will also only be allowed during the next Open Enrollment Period.

The Open Enrollment Period is from November 1 to November 30 each year with a January 1 effective date.

***Under no circumstances, will this Fund offer dependent coverage only. The employee must be a participant in the Managed Care Plan before his dependents are eligible for coverage.**

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

The Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act") and the regulations promulgated thereunder.

PHI is defined as individually identifiable health information that is maintained or transmitted in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, health plan (including this Plan), employer, health care clearinghouse; and relates to the past, present or future physical or mental health or condition of you or your eligible dependents; the provision of health care to you or your eligible dependents; or the past, present, or future payment for the provision of health care to you or your eligible dependents. When held by this Plan, it also means information that identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the

information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

PHI excludes individually identifiable health information in certain education records, in records of post-secondary education students made by a doctor or other professional in connection with treatment to the student, in employment records held by a Covered Entity in its role as an employer, and regarding a person who has been deceased for more than 50 years.

THE FOLLOWING USES AND DISCLOSURES OF PHI, AND CORRESPONDING RIGHTS AND DUTIES, APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS.

Permitted Uses and Disclosures of PHI

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

Required Uses and Disclosures of PHI

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

Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Use or Disclosure

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

Allowed Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, workers' compensation programs, correctional facilities, and when necessary to prevent or lessen a serious and imminent threat to health and safety. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administrative Office.

Prohibited Uses and Disclosures of PHI

This Plan will not use or disclose PHI that is genetic information for underwriting purposes, including determining eligibility or benefits under this Plan, for computing any contribution amounts under this Plan, or for other activities related to this Plan. In addition, this Plan will not sell PHI or receive remuneration in exchange for the use or disclosure of PHI, unless authorization is obtained as described below.

Uses and Disclosure of PHI that Require Your Written Authorization

This Plan must obtain your written authorization for any use or disclosure of your PHI not specifically required or permitted by law or described in this section. This Plan does not anticipate using or disclosing your PHI in a manner that would require your authorization. However, should an authorization be required, this Plan will provide you with an authorization form. You have the right to revoke your authorization at any time. All revocations will be honored by this Plan. If you do provide written authorization, it will allow PHI to be used and disclosed by both this Plan and its Business Associates.

Your written authorization will be obtained before this Plan will use or disclose psychotherapy notes about you from your psychotherapist, if applicable. 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. This Plan may use and disclose such notes without your written authorization when needed by this Plan to defend against litigation filed by you. Written authorization will also be obtained if PHI is used or disclosed for marketing purposes or is sold.

Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

1. You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request with one exception. The Plan is required to comply with

a restriction request if you request restricted disclosure of PHI to the Plan for payment or health care operations purposes (not for treatment purposes) and the PHI at issue relates solely to a health care item or service for which you (or person other than this Plan on your behalf) have paid the health care provider in full. In any other circumstances, if this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

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

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

4. You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a form to request an amendment to the PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. The Plan may deny your request to amend for any of the following reasons: (i) the request for amendment is not in writing; (ii) the request for amendment does not provide any

reason(s) for the requested amendment; (iii) the PHI or record that is the subject of the request was not created by the Fund unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment; (iv) the PHI or record that is the subject of the request is not part of a Designated Record Set; (v) the PHI or record that is the subject of the request is accurate or complete; or (vi) the PHI or record would not be available to you for inspection or copying as discussed above under the Access to PHI section. If the request is denied in whole or part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

5. You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for a six-year period starting from the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment, or health care operations or disclosures made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures: (i) incident to a use or disclosure otherwise permitted or required by law; (ii) made pursuant to your authorization; (iii) to individuals involved in your care or for notification purposes permitted by law; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement officials; and (vi) of a limited data set. You will be required to complete a form requesting an accounting of PHI disclosures by this Plan. This Plan will provide an accounting of disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. You have the right to request access to any Electronic Health Records ("EHRs") used or maintained by the Plan and this Plan will provide access to your EHRs in the electronic form and format requested by you if it is readily producible; or, if not, in a readable electronic form or format agreed to by this Plan and you. EHRs are electronic records of health-related information on an individual that are created, gathered, managed, and consulted by authorized health care clinicians and staff. In addition, you have the right to request that this Plan provide your EHRs to another entity or individual in electronic format so long as your request is clear, conspicuous and specific. The Plan is entitled to charge you a reasonable fee for any labor costs or supplies (e.g., portable electronic media) incurred in providing the electronic information. You will be required to complete a form requesting access to any EHRs or to have your EHRs provided to another entity or individual.

Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with a limited health care power of attorney regarding a specific treatment, such as use of artificial life

support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

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

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

The Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administrative Office has designated this group of employees to include Claims Adjusters, Claims File Clerks, Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

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

This Plan will limit, to the extent practicable, the PHI subject to use and disclosure to de-identified information, which excludes certain information that could be used to identify you. However, to the extent this Plan deems it necessary, it may use, disclose, or request more than de-identified information so long as it does not disclose, use, or request more than the minimum amount of your PHI necessary to accomplish the intended purpose of the use, disclose, or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes; disclosures made to you; uses or disclosures pursuant to your authorization; disclosures made to HHS or its OCR for enforcement purposes; uses or disclosures that are required by this Plan's compliance with HIPAA's Administration Simplification Rules.

Notification of Breach of Unsecured PHI

This Plan is required to notify you following a Breach of Unsecured PHI. No later than 60 days from the discovery of any Breach of Unsecured PHI, this Plan will provide you with notice of such Breach. Unsecured PHI includes PHI in electronic form that is not encrypted and PHI in paper form that has not been destroyed. A Breach of Unsecured PHI is an impermissible acquisition, access, use, or disclosure that compromises the security or privacy of such information unless this Plan (or Business Associate of this Plan, as applicable) can demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated. However, an impermissible acquisition, access, use or disclosure of PHI will not be considered a Breach if it is within one of the following three exceptions: (i) an unintentional acquisition, access, use or disclosure of PHI by a workforce member or person acting under the authority of this Plan or one of its Business Associates if made in good faith and within the course and scope of employment so long as the information is not further acquired, accessed, used or disclosed by any person; (ii) an inadvertent disclosure by an individual who is authorized to access PHI at this Plan or a Business Associate to another person who is also authorized to access PHI at this Plan or the Business Associate if the information is not further used or disclosed without authorization; or (iii) a disclosure of PHI for which the Plan or its Business Associate has a good faith belief that the unauthorized individual to whom the disclosure was made would not reasonably be able to retain it.

In the event of a Breach of Unsecured PHI, the Plan's written notification to you will include the following information: the date of the breach; the date of discovery of the breach; the type of PHI involved; the steps you should take to protect yourself from potential harm from the Breach; an explanation of what steps the Plan is taking to investigate the Breach, mitigate harm to you and to protect against further breaches; and contact procedures for you to obtain additional information. If the Plan lacks current contact information for you, it will provide substitute notice, which will be by email, telephone, or may be by other means including posting notice on the Plan's website or conspicuous notice in major print or broadcast media in the geographic area where you are likely to reside. In circumstances in which the Breach of Unsecured PHI is reasonably believed by the Plan to have affected more than 500 individuals in a particular state or jurisdiction, the Plan will provide additional notice to prominent media outlets within the state or jurisdiction no later than 60 days after discovery of the Breach. Finally, the Plan will report any Breach of Unsecured PHI to HHS as required by HHS.

Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you. For example, health information is de-identified if certain identifiers are removed, including but not limited to your name, geographic identifiers (e.g., address, etc.), all elements of dates relating to you (e.g., your birth date), Social Security Number, telephone number, medical record number, etc.

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

Although the Plan is allowed to use and disclose your PHI for marketing purposes with your written authorization, this Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication about a product or service that encourages recipients of the communication to purchase or use of the product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, marketing does not include the following communications made, unless direct or indirect payment is received from or on behalf of a third party whose product or service is being described: (i) to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual (payment may be received if it is reasonably related to the cost of making the communication); (ii) for the treatment of an individual by a health care provider, including case management or care coordinating for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual; (iii) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in the plan of benefits of the entity making the communication, including communications about participating in a health care provider network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan enrollee that add value to, but are not a part of, a plan of benefits; or (iv) for care management or care coordination, contacting of individuals with information about treatment alternatives, and related functions.

This Plan does not anticipate making any fundraising communication; however; to the extent this Plan provides you with any written fundraising communication that is a healthcare operation as defined under the Privacy Rule, it shall provide in a clear and conspicuous manner that you are entitled to elect not to receive any further such communication and such election shall be treated as a revocation of authorization.

The Board of Trustees' Duties

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended the Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by this Plan's documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address: Ed Simon, Benefit Programs Administration, 1200 Wilshire Boulevard, Fifth Floor, Los Angeles, California 90017-1906. A complaint may also be filed with the HHS in

writing, either electronically via the OCR Complaint Portal, or on paper by faxing, emailing, or mailing it to the applicable OCR regional office. For more information on filing a complaint with HHS, please visit **www.hhs.gov/ocr/privacy/hipaa/complaints/** or call 800-368-1019 to request a copy of a complaint form.

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

SECURITY STANDARDS UNDER HIPAA

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

NOTICE TO THOSE ELIGIBLE FOR MEDICAID

Current laws and regulations require that the Trust Fund provide primary coverage for active employees, their spouses, and other dependents covered under the Plan with state Medicaid programs providing secondary coverage. This means that in enrolling an employee, an employee's spouse or dependents, or in determining or making payment for benefits for those participants and beneficiaries, the Trust Fund cannot take into account that these individuals are also covered by a state Medicaid program.

The Plan will honor any assignment of rights made by or on behalf of such a participant or a beneficiary of the participant as required by a state Medicaid program. The Plan will also honor any state acquired rights from third parties. The Plan in these instances will reimburse any state Medicaid program if payment was made by such state program and the Plan should have been responsible for the payment of the medical services. The state Medicaid program will be reimbursed in accordance with the terms and conditions of the Plan. You should contact the Administrative Office if you have any questions.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In compliance with the Women's Health and Cancer Rights Act of 1998, when a participant or beneficiary receiving benefits under the Plan elects breast reconstruction in connection with a mastectomy, the Fund will provide coverage for 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 of all stages of the mastectomy, including lymphedemas. Federal law requires this coverage, in a manner to be determined in consultation with the attending Physician and patient.

NEWBORNS'AND MOTHERS' 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The length of stay begins at the time of delivery of the child in the Hospital. If the delivery occurs outside the Hospital, the length of stay begins at the time the mother or newborn is admitted in connection with the childbirth. The determination of whether the admission is in connection with childbirth is a medical decision to be made by the attending provider.

MEDICAL PLAN BENEFITS

Introduction

The Fund provides two options for medical coverage under the Managed Care Plan: the Indemnity Medical Plan and one HMO plan. Kaiser Permanente is the HMO plan offered by the Fund.

Choice of Plans

NOTE: You must enroll in a plan. This is your responsibility.

Available medical plans:

1. Indemnity Medical Plan (PPO)
2. Kaiser Permanente (HMO) (Not available to out of state residents)

Enrollment

INITIAL ENROLLMENT

Newly hired employees, or employees transferring into this Plan from another Plan, must complete an Enrollment and Plan Selection Form designating the medical plan in which they wish to enroll within 90 days of the date they first become eligible. IF NO CHOICE IS MADE OR THE ENROLLMENT FORM IS NOT RETURNED, THE MEMBER WILL AUTOMATICALLY BE PLACED IN THE INDEMNITY MEDICAL PLAN. Once you have made a choice of plans, you and your eligible enrolled dependents will remain covered by that plan as long as you remain eligible unless you fill out an Enrollment and Plan Selection Form changing your original selection during the Managed Care Plan's Annual Open Enrollment Period. Please, however, see the section entitled "HIPAA Special Enrollment Rights" on page 16 of this Plan Booklet for additional information.

ANNUAL OPEN ENROLLMENT

If you are eligible for Indemnity Medical or HMO medical coverage you will have the opportunity to change your plan selections during the Managed Care Plan's Annual Open Enrollment period. During the month of November of each year you may change your plan selection for the 12 months commencing the following January 1. Information on the plans available to you is mailed in November of each year. If you wish to make a change in your plan selection it is your responsibility to complete an Enrollment and Plan Selection Form and submit it to the Administrative Office.

Once you have made your choice, you will remain in that plan, even though you may change employers, except that if you return to work after you are not reported to the Fund for a period of six months, it will again be necessary for you to enroll in the plan of your choice.

If you have any questions regarding your coverage or if you have not received an enrollment card, please call the Administrative Office at (562) 463-5080 or (800) 824-4427.

INDEMNITY MEDICAL PLAN

The Self-Funded Indemnity Medical Plan will reimburse the costs of most medical expenses under the terms and conditions of this Plan Booklet, leaving only a portion of the medical bill to be paid by you. Medical providers are utilizing more procedures and charging more for their services than ever. The Plan utilizes Hospital preauthorization, case management, and Preferred Provider Organization (PPO) programs to manage costs while providing appropriate medical benefits.

You have the choice to use these cost management programs and avoid additional out-of-pocket costs, or not use them and pay more for your medical care.

Summary of Benefits

BENEFIT	**INDEMNITY MEDICAL PLAN COVERAGE**	
	Blue Cross PPO Provider	**Non-PPO Provider**
Maximum Lifetime Benefit (while otherwise eligible) for essential health benefits	None	
Calendar Year Maximum Benefit (while otherwise eligible) for essential health benefits	None	
Deductible	None	$150
Out-of-Pocket Maximum	$6,600/person* $13,200/family* * Combined with prescription drug out-of-pocket costs (e.g., co-payments) for prescription drugs covered under the indemnity prescription drug program. * Pediatric dental expenses paid by you for covered pediatric (ages 0 through 18) oral services through the Scheduled Dental Plan will count towards the per-person or per-family Out-of-Pocket Maximum, as applicable (if you are enrolled in both the Indemnity Medical Plan and the Scheduled Dental Plan). * Pediatric vision expenses paid by you for covered pediatric (ages 0 through 18) vision services through the Vision Benefits Plan will count towards the per-person or per-family Out-of-Pocket Maximum, as applicable (if you are enrolled in both the Indemnity Medical Plan and the Vision Benefits Plan). * May be increased in the future, as permitted under section 1302 (c) (1) of the Patient Protection and Affordable Care Act of 2010.	None

BENEFIT	Blue Cross PPO Provider Plan Pays: (Plan pays a percentage of PPO contract rate)	Non-PPO Provider Plan Pays: (Plan pays a percentage of a Schedule of Covered Charges)
Professional Services Doctor's Visit – Office and Hospital	85% of Contract Rate	70% of Covered Charges
X-ray/Lab	85% of Contract Rate	70% of Covered Charges
Surgery	85% of Contract Rate	70% of Covered Charges
Anesthesia	85% of Contract Rate	70% of Covered Charges
Preventive Services (as specifically provided for under "Covered Services and Supplies" on pages 39 to 42)	100% of Contract Rate	70% of Covered Charges
Maternity Care (Members and spouses only; Dependents covered only for complications of pregnancy)	85% of Contract Rate	70% of Covered Charges
Durable Medical Equipment, Artificial Aids and Corrective Appliances	85% of Contract Rate	70% of Covered Charges
Emergency Services	85% of Contract Rate	85% of Covered Charges
Physical Therapy, Chiropractic Services, and Acupuncture	85% of Contract Rate	70% of Covered Charges (40 visits per year)
Skilled Nursing, Extended Care and Convalescent Care	85% of Contract Rate (60-day maximum per Benefit Period)	70% of Covered Changes (60-day maximum per Benefit Period)
Home Health Care	85% of Contract Rate	70% of Contract Rate
Hospice Care	85% of Contract Rate	70% of Covered Charges
Hospital/Facility Charges	85% of Contract Rate*	70% of Covered Charges* Maximum Covered Charges: Medical, Surgical, Maternity & Intermediate Care $1,000/day Intensive Care Unit (ICU) $1,550/day
Mental Health & Substance Abuse Outpatient	85% of Contract Rate	70% of Covered Charges
Inpatient (including Residential Treatment Facilities)	85% of Contract Rate*	70% of Covered Charges Maximum Covered Charges of $1,000/day)

* Pre-Admission Authorization available through Anthem Blue Cross (see pages 38 through 39).

Lifetime Maximum Benefit (While Otherwise Eligible)

There are no dollar-amount lifetime maximum benefits with respect to "essential health benefits" provided under the Plan. Essential health benefits include the following, if otherwise covered under the terms of the Plan:

(a) ambulatory patient services;
(b) emergency services;
(c) Hospitalization;
(d) maternity and newborn care;
(e) mental health and substance use disorder services, including behavioral health treatment;
(f) prescription drugs;
(g) rehabilitative and habilitative services and devices;
(h) laboratory services;
(i) preventive and wellness services and chronic disease management; and
(j) pediatric services, including oral and vision care.

Certain maximums, such as lifetime (or annual) dollar value limits on non-essential health benefits or limits on number of visits, etc., still apply to specific periods, conditions, or types or levels of care. For example, there is a 60-day maximum per Benefit Period for Skilled Nursing, Extended Care, and Convalescent Facility care. In addition, the per-day dollar maximums for non-PPO medical, surgical, maternity, , and intermediate care; per-day dollar maximums for non-PPO intensive care unit (ICU) services; and other calendar year visit/confinement limitations (described further below) are applicable.

Calendar Year Maximum Benefit (While Otherwise Eligible)

There are no calendar year maximums.

Calendar year visit/confinement and day limitations are applicable to out-of-network physical therapy, chiropractic services, and acupuncture.

Deductible

There is no deductible if you use a Blue Cross PPO provider. If a Non-PPO provider is used, the calendar year deductible is $150. This means the Fund will not pay the first $150 of the Covered Charges it normally would have paid.

The maximum number of people in a family who must pay the deductible is three (3). The maximum family deductible is $450 ($150 individual deductible x 3) if a Non-PPO provider is used. Therefore, at least three people in the family must meet the deductible prior to the waiver of any remaining individual deductible.

A deductible that is paid during the last three months of a calendar year will be used toward the deductible for the next calendar year. Only Covered Charges to which a deductible applies may be used to satisfy the deductible.

Out-of-Pocket Maximum

There is an out-of-pocket maximum of $6,000/person and $13,200/family (may be increased in the future, as permitted under section 1302 (c) (1) of the Patient Protection and Affordable Care Act of 2010) if you use a Blue Cross PPO provider. The out-of-pocket maximum includes your percentage of the PPO Contract Rate, as well as any copayments and deductibles, and starting in 2015, any cost-sharing (e.g., copayments) for prescription drugs covered under the indemnity prescription drug program. Also, beginning in 2015, pediatric dental and vision expenses paid by you for covered pediatric (ages 0 through 18) dental and vision services through the Scheduled Dental Plan and the Vision Benefits Plan, respectively, will count towards the per-person or per-family Out-of-Pocket Maximum, as applicable. There is no out-of-pocket maximum if you use a Non-PPO provider.

If you and your family incur covered medical expenses as the result of a common accident, only one deductible will be applied toward the Covered Charges incurred due to that accident, during that calendar year. If greater benefits would be payable without this provision, then it will not apply.

Amount Payable By Fund

BLUE CROSS PPO PROVIDERS
The Trust Fund has contracted with Hospitals, Physicians, and other providers through the Blue Cross Preferred Provider Organization (Blue Cross PPO). The providers in the Blue Cross PPO network have agreed to provide services at specified contract rates lower than Reasonable and Customary Charges. The Fund will pay **85% of the contract rate,** if the services incurred are otherwise covered by the terms of this Plan Booklet, i.e., the Plan's medical necessity determinations, or any other plan exclusions and/or limitations still apply, etc. You will be responsible for the remaining 15% (up to the out-of-pocket maximum). See pages 36 to 38 of this Plan Booklet for more information on the Blue Cross PPO network.

NON-PPO PROVIDERS
Subject to the deductible, the Fund will pay up to **70% of Covered Charges** for services received from Hospitals and medical care providers that are not in the Blue Cross PPO network (except for emergency services provided in an emergency department of a Hospital, which will be paid at 85% of Covered Charges); if the services incurred are otherwise covered by the terms of this Plan Booklet, i.e., the Plan's medical necessity determinations or any other plan exclusions and/or limitations still apply, etc. Please see below for a definition of Covered Charges.

Covered Charges

The Covered Charge is the **lesser of the service provider's charge** or the **Maximum Covered Charge** as established by the Fund.

MAXIMUM COVERED CHARGES
When you use a Non-PPO provider, the Fund has no way of controlling the charges of that provider. Therefore, the Fund has established Maximum Covered Charges.

1. **Hospital/Facility Covered Charges (Inpatient)**
   The following Maximum Covered Charges apply to facility/room charges incurred while an inpatient at a Non-PPO Hospital/facility, including psychiatric/mental health and substance abuse inpatient charges.

(Level 1)	Medical (including psychiatric/mental health and substance abuse), Surgical, Maternity, and Intermediate Care	$1,000 per day
(Level 2)	Intensive Care Unit (ICU)	$1,550 per day

2. **Emergency Services Covered Charges**
   The Maximum Covered Charge for Emergency Services provided in an emergency department of a Hospital will be the greater of the following amounts: (1) the median of negotiated in-network rates; (2) the generally applicable out-of-network costs (i.e., the Usual, Customary, and Reasonable (UCR) Charges); or (3) the Medicare rate.

3. **Physician/Professional Covered Charges (Inpatient and Outpatient)**
   The Maximum Covered Charge for a given treatment/procedure will not exceed the amount allowed in the EMC Captiva (UCR) Database guidelines at the 50th percentile. The 50th percentile means that 50% of providers charge at or below the 50th percentile charge.

4. **Physical Therapy, Chiropractic, and Acupuncture Maximums**
   The Maximum Covered Charge for services received from a Non-PPO provider for covered Physical Therapy, Chiropractic and Acupuncture services is limited to 40 total treatment days per calendar year.

Outside Geographic Area

For eligible individuals residing and receiving benefits outside of the geographic area of the Fund, Emergency Services will be paid at 85% of Covered Charges and other covered services will be paid at 70% of the Usual, Customary, and Reasonable (UCR) Charges, as determined by the Fund, subject to the deductible.

For eligible individuals traveling outside of the geographic area of the Fund, Emergency Services will be paid at 85% of Covered Charges and urgent care services will be paid at 70% of the Usual, Customary, and Reasonable (UCR) Charges, as determined by the Fund, subject to the deductible (no other services will be covered).

Health Care Provider Choices

The Fund does not require that you designate a primary care provider. You may choose to see any provider (s) that you wish.

Similarly, no authorization or referral is required if you are female and seek obstetrical and gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology (i.e., an OB-GYN).

Anthem Blue Cross of California PPO Provider Network

Anthem Blue Cross of California is the Fund's Preferred Provider Organization (PPO). The health care providers in this network have agreed to reduce their charges to the Fund and you. Therefore, if you use a Blue Cross PPO provider and/or Hospital, your out-of-pocket cost can be reduced substantially.

YOUR LOWEST COST WILL BE FROM A BLUE CROSS PPO PROVIDER

For all services, you will be required to pay the difference between the provider's charge and the Fund's payment amount. In most cases there will be a very large difference between the amount a Non-PPO provider charges and the amount the Fund will pay a Non-PPO provider.

By using a Blue Cross Provider, you save money in three ways:

1. No deductible;
2. Blue Cross PPO contract rates are generally lower;
3. The Fund pays a higher percentage of medical charges; and
4. Expenses are limited to the out-of-pocket maximum.

COST COMPARISON EXAMPLE

Hospital Services Out-of-Pocket Expenses: Blue Cross PPO and Non-PPO Providers

Blue Cross PPO Provider	
Provider Charge (Contract Rate)	$2,000
Fund Pays (85% of Contract Rate)	$1,700
Your Deductible	$0
You Pay (15% of Contract Rate)	$300

Non-PPO Provider	
Provider Charge (No Contract Rate–provider's actual charges are usually higher than Blue Cross PPO provider charges)	$2,000
Covered Charges (Example Only) (Maximum Covered Charge)	$1,428.57
Fund Pays (70% of Contract Rate)	$1,000
Your Deductible	$150
You Pay Deductible ($150) + 30% of Covered Charges (428.48) + Difference between Covered Charges and provider's actual charge ($421.42)	$1,000

How to Find a Blue Cross PPO Provider

DIRECTORY
You can find a list of Blue Cross PPO contracting providers in the directory provided by Blue Cross. Directories are available from the Administrative Office.

INTERNET
You can also find a current list of Blue Cross PPO providers on the Blue Cross web site.

1. Go to **http://www.bluecrossca.com**.

2. Click on the "Find a Doctor or Hospital (Provider Finder)" link
   - You will be guided through a series of steps to identify the type of Plan and Provider you are seeking.
   - The Plan type is: Large Group Plan
   - The Plan network type is: Blue Cross PPO (Prudent Buyer)

Referral to Blue Cross PPO Hospital

If you use a Blue Cross PPO doctor, they should automatically recommend the use of a Blue Cross PPO Hospital. However, you should confer with your Blue Cross PPO doctor when Hospitalization is necessary to make sure you are admitted to a Blue Cross PPO Hospital when possible. If you use a non-PPO doctor, and your condition requires the use of a Hospital, either as an inpatient or outpatient, **tell your doctor that you want to use a Blue Cross PPO Hospital** so that you can reduce your out-of-pocket costs.

If you use a Blue Cross PPO doctor and it is necessary for you to be referred to another doctor or health care provider, **ask your doctor to refer you to a Blue Cross PPO Provider**. If you are referred to or have services rendered by a non-PPO provider, charges will be subject to the deductible and less benefits will be paid. This means you will have greater out-of-pocket costs. **PLEASE NOTE:** YOU CAN USE BLUE CROSS FOR PRE-ADMISSION AUTHORIZATION/UTILIZATION REVIEW EVEN IF YOU USE A NON-PPO PROVIDER. (SEE BELOW FOR DETAILS.)

Anthem Blue Cross of California Pre-Admission Authorization and Utilization Review

Anthem Blue Cross of California is the Fund's contracting provider for pre-admission authorization/ utilization Review.

WHAT IS PRE-ADMISSION AUTHORIZATION/UTILIZATION REVIEW
Pre-Admission Authorization is a program designed to avoid unnecessary Hospitalization. Through this review process, your doctor and you will be advised if an inpatient Hospital stay is medically necessary. Perhaps a recommended surgery can be performed on an outpatient basis thus saving you and the Trust Fund the cost of days spent in the Hospital. If Blue Cross has a question as to the necessity of Hospitalization, your doctor and Blue Cross will resolve the problem. Blue Cross will also determine the appropriate length of stay as it relates to your current medical condition.

DO I HAVE TO USE A BLUE CROSS PPO PROVIDER AND BLUE CROSS PRE-ADMISSION AUTHORIZATION?
It is your choice. You can choose to use Blue Cross PPO providers and Blue Cross preauthorization or not. If you choose to use non-PPO providers, **your out-of-pocket expenses will be higher** than if you use Blue Cross PPO Providers. If you choose not to get pre-admission authorization from Blue Cross, any services rendered which are not medically necessary for the treatment of the injury or illness, as determined by Physician advisors of Blue Cross, **will not be paid.**

HOW TO USE PRE-ADMISSION AUTHORIZATION
A Hospital pre-admission certification through Blue Cross can be obtained by a member before he is admitted to a Hospital as an inpatient. Pre-admission certification can be done for both Blue Cross PPO and non-PPO Hospital admissions. If it is not done, any charges incurred for services or supplies which are rendered that are not medically necessary for the treatment, will not be paid.

To obtain pre-admission authorization please call Blue Cross at **(800) 274-7767**. Hours of operation are Monday through Friday from 7:30 a.m. to 5:30 p.m.

For standard non-emergency procedure, Blue Cross recommends allowing five (5) business days for your preauthorization request to be processed. In case of an emergency, please call Blue Cross as soon as possible at the number above.

In the event a member obtains services from a Hospital on an emergency basis, the Physician should, but is not required to notify Blue Cross either (a) within 48 hours of the services if it occurs

on a day other than a Saturday, Sunday, or a holiday, or (b) within 72 hours if it occurs on a Saturday, Sunday, or a holiday.

Blue Cross' authorization means that the Hospitalization or services rendered are medically necessary. This does not necessarily mean that the Hospitalization or services are covered benefits under the Plan. For this information, you must call the Administrative Office at (562) 463-5080 or (800) 824-4427.

Covered Services and Supplies

The Plan covers medically necessary treatment, services and supplies in accordance with the covered benefits, limitations and exclusions described in this Plan Booklet.

HOSPITAL CARE
Covered services are:

1. Daily Hospital services for a semi-private room for each day of confinement as a registered inpatient.

2. Hospital services for other medical services and supplies provided during confinement as a registered inpatient.
3. Medical services and supplies provided by a Hospital during outpatient care of a member.

4. Emergency Services provided in an emergency department of a Hospital.

5. Intensive care unit services.

6. The charges from a Skilled Nursing, Extended Care or Convalescent Facility, but only if the Member has been a registered Hospital inpatient for a period of at least three consecutive days, and is confined in the Skilled Nursing, Extended Care, or Convalescent Facility within seven days after discharge from the Hospital. Coverage is limited to 60 days per Benefit Period.

7. Professional ambulance to transport the member to or from a Hospital or extended care facility where treatment is given.

SURGICAL CARE
Covered services are:

1. Surgery or radiotherapy by the operating Physician.

2. Assistant surgeon charges when attendance by the assisting Physician is medically necessary.

3. Administration of anesthesia during surgery by an anesthesiologist or licensed anesthetist.

4. Administration of anesthesia by the operating or assisting Physician at reduced benefits, including local infiltration digital block, or topical anesthesia.

5. The attendance of a second surgeon on the same care at the same time when the attendance is medically necessary.

MEDICAL CARE
Covered services are:

1. Physician treatment of a member while he is confined in a Hospital as a registered inpatient.

2. Physician treatment for care (a) rendered in a Physician's office, or (b) rendered in a place other than a Hospital or a Physician's office.

3. Physician treatment of a psychiatric/mental health condition such as a mental, nervous or emotional disorder/illness or substance use disorder condition.

RESIDENTIAL TREATMENT FACILITY CARE
Covered services are:

1. Charges for room, board, and general care. If a private room is used and it is not Medically Necessary, charges that are more than the facility's most common semi-private room rate will not be considered covered charges. You are responsible for the excess charges. If the facility does not have semi-private rooms, that part of the facility's daily charge in excess of the area's prevailing rate for semi-private rooms will not be considered a covered charge; and

2. Charges for mental health and substance use disorder services and supplies required for treatment, including prescription drugs approved by the Federal Drug Administration, which are provided by the facility and used while admitted in the facility.

DIAGNOSTIC LABORATORY AND X-RAY CARE
Covered services are:

1. The services of a Physician, radiologist, pathologist, or laboratory for actual services rendered for a diagnostic laboratory or x-ray examination.

PREVENTIVE SERVICES
Covered services are:

1. Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults (i.e., those immunizations that have been adopted for recommendation by the Centers for Disease

Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention);

3. Preventive care and screening for infants, children, and adolescents, as provided for in the comprehensive guidelines by the Health Resources and Services Administration ("HRSA"); and

4. Preventive care and screening for women, as provided for by the HRSA that are not otherwise addressed by Task Force recommendations.

DURABLE MEDICAL EQUIPMENT AND PROSTHETICS
Covered services are:

1. Rental of a wheel chair, Hospital bed, and other similar, durable medical equipment.

2. Charges for initial prosthetic devices required to replace natural limbs or eyes.

3. Casts, splints, and surgical dressing.

HOME HEALTH CARE
Covered services are:

1. Medically necessary services ordered by a Physician and rendered by a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed physical therapist. A doctor may request home health care and it may be determined to not be medically necessary and, therefore, not covered.

HOSPICE CARE
Covered Services are:

1. Charges for room and board and general nursing care for a terminally ill person in a freestanding hospice;

2. Charges for homemaker services; and

3. Charges for Emotional Support Services to assist in coping with the death of a terminally ill person provided in counseling sessions with the patient or the family. Covered expenses for counseling with the family will not exceed $200 for all counseling sessions prior to and within six months after the death of the terminally ill person.

PREGNANCY
Benefits for treatment of pregnancy and complications thereof are covered on the same basis as benefits for the treatment of disease. Pregnancy benefits for dependent children are limited to complications of pregnancy only (except as otherwise covered under Preventive Services). Pregnancy complications include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy which terminated, cesarean section, spontaneous termination of

pregnancy which occurs during a period of gestation in which viable birth is not possible, and similar medical and surgical conditions.

Under the Newborns' and Mothers' Health Protection Act of 1996, the Plan will provide for a Hospital stay of no less than 48 hours for the eligible mother and newborn child following a vaginal delivery (with or without complications), and no less than 96 hours for a cesarean birth, unless an attending Physician in consultation with the mother approves an earlier discharge. The time periods outlined above begin at the birth of the child. Blue Cross' Pre-Admission Authorization procedures must still be followed, however. Blue Cross cannot, under Federal law, authorize a length of stay less than 48 hours or 96 hours, as applicable, unless an attending Physician in consultation with the mother approves an earlier discharge.

ACUPUNCTURE, CHIROPRACTIC, AND PHYSICAL THERAPY
Covered services are those services rendered by a person practicing within the scope of his license or certification. These services are limited to the maximum number of treatments as set forth on page 35 of this Plan Booklet.

ORGAN TRANSPLANTATION
Covered Services are:

1. Non-experimental, medically necessary organ transplants. Pre-admission authorization through Blue Cross can be obtained and is recommended. Blue Cross uses Centers of Excellence Hospitals in California that specialize in organ transplants under a PPO contract rate. You are not required to use a Center of Excellence for an organ transplant; however, your out-of-pocket expenses are lower by using a preferred facility. You may call Blue Cross at (800) 274-7767 for further information.

2. Expenses for a live donor as if they were expenses of an eligible participant provided the eligible participant received an organ transplant from the live donor.

3. Services in connection with: selection, removal (harvesting) and evaluation of the donor organ, bone marrow, or stem cells; transportation of the donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage for bone marrow and stem cells for a period of up to 12 months.

Excluded donor expenses include those incurred for a transplant that is not covered by the Plan, or for a recipient who is not an eligible participant in this Plan.

Limitations and Exclusions

The Indemnity Medical Plan does not pay expenses for:

1. Treatment for any bodily injury or disease that results from employment or occupation for compensation.
2. Treatment, service, or supply that is not medically necessary.

3. Any service or supply that is not prescribed by a Physician.

4. Services rendered that are not in the treatment of an illness or injury.

5. Services for which you are not required to pay, if you did not have this coverage (you must also have been billed for the treatment, service, or supply).

6. Benefits for a covered service will not be paid under more than one coverage, or more than once under this coverage.

7. Benefits for treatment of a mental, nervous, or emotional disorder or condition by a psychiatric/mental health registered nurse are subject to the same exclusions or limitations in effect under the Plan that apply to services rendered by a Physician for the treatment of a mental, nervous, or emotional disorder or condition (or by a Physician for the treatment of any medical condition).
8. Treatment of injury or illness as the result of war, whether declared or undeclared.

9. Treatment by one who normally resides in the member's home or who is the wife, husband, child, brother, sister or parent of either the member or his spouse.

10. Medical examinations, services and supplies not necessary for the treatment of any injury or illness.

11. Eye examinations and eye glasses or contact lenses.

12. Hearing aids and examinations or test of their fit and effectiveness.

13. Cosmetic surgery, except for repair of accidental damage within one year of the accident.

14. Dental services or supplies unless the treatment is for accidental damage to sound natural teeth which have not been extensively restored or have not become extensively decayed or diseased. Treatment must be the result of an accident and the treatment must be done within one year of the accident.

15. Vision correction surgery (lenses or contact lenses) and other procedures to correct faults of refraction in lieu of optical correction.

16. Treatment for obesity, or complication(s) from any treatment thereof, including gastric bypass surgery or any related surgeries and services (except as otherwise covered under Preventive Services).

17. Treatment for an injury or illness which was a result of participation in a or consequence of the commission of a felony or misdemeanor.

18. Injury or illness arising from or sustained in the course of any criminal activity, including a riot.

19. Surgery or services provided when no illness or injury is involved.

20. Injuries or illness caused through the act or omission of a third party, where you are pursuing or you intend to pursue a claim or lawsuit against a third party.

21. Any supplies or services for which you are not required to pay, which are furnished by or payable under any plan or law of any government or furnished by a county or municipal Hospital where there is no legal requirement to pay for such supplies or services.

22. Any disability covered by a workers' compensation or occupational disease law.

23. Services for the promotion, prevention or other treatment of hair loss or hair growth.

24. Services in connection with a surrogacy arrangement.

25. Transgender surgery and services.

26. Services related to or complications resulting from a service that is not covered by this Plan. (This provision shall not be applied so as to limit treatment for pre-existing conditions.)

27. Injury or illness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain.

28. Experimental or investigational treatment of an injury or illness. Any services or procedures that are experimental in nature, as determined by the American Medical Association or that are not within the standards of generally accepted medical or dental practice (except that the Fund shall not deny participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; shall not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and shall not discriminate against an individual on the basis of the individual's participation in a clinical trial, in accordance with the Patient Protection and Affordable Care Act of 2010, and any regulations issued thereunder).

29. Infertility benefits.

Government Benefits

If a member is entitled, or could have been entitled, if proper application had been made, to any medical, dental, or disability benefit provided under the authority of any governmental agency, such benefit shall discharge the obligation of the Southern California Lumber Industry Welfare Fund as though it had been under this insurance, but no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a State or by a political subdivision of a State.

Definitions

Benefit Period: a period beginning with the day the Member is admitted as an inpatient in a Hospital (prior to a confinement at a Skilled Nursing, Extended Care, or Convalescent Facility) and ending when the Member has not received any inpatient or Skilled Nursing, Extended Care, or Convalescent Facility care for 60 consecutive days.

Contract Rate: Hospitals, Physicians and other medical service providers in the Blue Cross PPO network have agreed to charge a pre-determined contract amount for their services.

Covered Charge: the lesser of the Non-PPO service provider's charge or the Maximum Covered Charge as established by the Fund and described on pages 34 to 35 of this Plan Booklet.

Deductible: the amount of Covered Charges which must be incurred by a member before benefits will be paid by the Plan. (No benefits are payable for Covered Charges applied toward a deductible.)

Emergency: A medical condition with acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: Medical screening examination or evaluation of an Emergency that is within the capability of an emergency department of a Hospital (and any ancillary services routinely available to the emergency department of a Hospital), and treatment to stabilize the patient.

Home Health Care: means intermittent Medically Necessary skilled health care services delivered in the home of an eligible Participant under orders of a Physician that is provided to Participants who are essentially homebound for medical reasons and physically unable to obtain necessary medical care on an outpatient basis.

Hospice Care: means those services provided in accordance with a Hospice Care Plan for a terminally ill person diagnosed by a Physician as having six months or less to live. Hospice benefits will be paid for charges made by a Hospice Care Team and are in addition to benefits that are provided under the other medical benefits of the Plan.

Hospital: only an institution which meets all the following tests: (1) primarily provides medical treatment to registered inpatients; (2) maintains facilities for diagnosis and surgery; (3) provides treatment only by or under a staff of Physicians; (4) provides 24-hour-a-day care by registered nurses; (5) maintains a daily medical record for each patient; (6) complies with all licensing and other legal requirements; and (7) is not, except incidentally, a place for rest or custodial care of the aged, senile, etc.; a nursing home; a hotel; or similar institution.

Intensive Care Unit: a separate Hospital service area which: (1) is solely for treatment of patients in a critical condition; (2) continuously provides special nursing care and observation; (3) provides special lifesaving equipment; (4) contains at least two beds for critically ill patients; and (5) provides at least one registered nurse in such area on a 24-hour-a-day basis.

Medically Necessary: with respect to each service or supply, the term "medically necessary" means that the service or supply meets all of the tests listed below:

1. It is rendered for the treatment or diagnosis of an injury or illness, including premature birth, congenital defects, and birth defects;

2. It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;

3. It is not mainly for the convenience of the member or the member's Physician or other provider; and

4. It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a Hospital or other facility, this test means that the member needs to be confined as an inpatient due to the nature of the services rendered or due to the member's condition and that the member cannot receive safe and adequate care through outpatient treatment.

Member: you or your dependent when covered under the Plan.

Non-PPO Provider: any health care provider or facility that is NOT part of the Blue Cross PPO Provider network.

Physician: only a person who is practicing within the scope of his license or certification as a Doctor of Medicine or a Doctor of Osteopathy; or to the extent that benefits are provided, as a Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, Licensed Optician, Psychologist; or when performing services upon referral, by a licensed or certified Doctor of Medicine or Doctor of Osteopathy, a licensed Physician's Assistant, a licensed Nurse Practitioner, a licensed clinical social worker, a licensed marriage, family, and child counselor, or a registered psychiatric-mental health registered nurse or other service providers practicing within the scope of their licenses or certifications, as applicable and to the extent that benefits are provided.

Plan Year: a period beginning January 1 and ending on December 31 of each calendar year.

PPO Provider: any health care provider or facility that is contracted with Blue Cross as part of the Blue Cross PPO Provider network.

Pregnancy: any pregnancy, a complication thereof, or the termination of a pregnancy.

Professionally Recognized Standards: means professionally recognized standards of quality, as determined by the Board of Trustees and/or its medical consultant. To determine such standards, such groups as the American Medical Association, the American Dental Association, their affiliates and successors, peer review groups, professional review groups, and similar groups will be used.

Residential Treatment Facility: a psychiatric treatment facility or chemical dependency treatment facility or chemical dependency treatment facility accredited under the Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, which:

1. is mainly engaged in providing assistance in the treatment of mental health and substance use disorders/withdrawal from dependency on alcohol or drugs;

2. is supervised by a staff of Physician on the premises; and

3. provides on the premises 24-hour nursing service by graduate registered nurses.

Skilled Nursing, Extended Care, or Convalescent Facility: an institution which meets all the following tests: (1) primarily provides skilled nursing care to registered inpatients under 24- hour-a-day supervision of a Physician or registered nurse; (2) has available at all times a Physician who is a staff member of a Hospital; (3) has on duty 24-hours-a-day a registered nurse, or licensed vocational nurse; (4) maintains a daily medical record for each patient; (5) complies with all licensing and other legal requirements, and (6) is not, except incidentally, a place for rest or custodial care of the aged, senile, etc.; a nursing home; a hotel; or similar institution.

Coordination of Benefits

The benefits payable for covered charges incurred will be coordinated with any other group insurance you or your dependents may have.

Coordination means that benefits are paid so that no more than 100% of Usual, Customary and Reasonable (UCR) expenses will be covered under the combined benefits from all the following plans: (1) this Plan; (2) any other group, blanket, or franchise insurance coverage; (3) group practice and other group prepayment coverage; (4) group service plans; (5) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; (6) any coverage provided under governmental programs, and (7) any coverage required or provided by statute.

The Fund may obtain or release any information necessary to carry out these provisions, subject to the HIPAA Privacy Rule and Regulations. You must declare your coverage under other plans. The Fund can recover from the member amounts that are overpaid to him.

In the processing of claims where two or more companies or plans are involved, this Fund follows the “Primary-Secondary Rule.” The primary plan is the plan which pays first on the claim. If a balance is still due after the primary plan’s payment, the claim should be sent to the secondary plan for consideration.

GENERAL RULE
In determining which of the plans is primary or secondary, this Trust Fund will apply the rules outlined below. The first rule which applies to the situation will be used.

1. The plan without a coordination of benefits provision is always primary.

2. The plan covering the person as a participant is primary to the plan covering the person as a dependent.

3. The plan covering the person as an active participant is primary to the plan covering the person as a retiree or self-pay participant.

4. The plan covering the person for the longest continuous period is primary to the plan covering the person for a shorter period if the person has the same type of eligibility in both plans.

DEPENDENT CHILD RULES
In the case of a dependent child where the parents are not divorced, this Plan uses the "birthday rule." This means the plan of the parent whose birthday occurs earlier in the calendar year is primary. If the other plan does not have the birthday rule, the other plan's rules will determine who is primary.

In the case of a dependent child where the parents are divorced, the rules are:

1. If the parent with custody has not remarried, the plan of the custodial parent is primary to the plan of the non-custodial parent.

2. If the parent with custody has remarried, the plan of the custodial parent is primary, the plan of the custodial stepparent is secondary and the plan of the non-custodial parent is third.

3. If a Qualified Medical Child Support Order (QMCSO) provides a different order of benefit determination, the QMCSO order will be followed. A copy of the QMCSO order will be required.

Once responsibility for primary payment is established, the Plan proceeds in one of two ways:

1. If this Trust Fund is responsible for payment as the primary plan, it will pay benefits in the regular manner, with no consideration of what the secondary plan may or may not pay.

2. If this Trust Fund is the secondary plan, it will begin by determining how much it would have paid had there been no other group coverage. Next it will find out what the primary plan will/did pay. Then it will make a payment for the difference between the Contract Rate or the total Covered Charge and the amount paid by the primary plan, but not to exceed the total liability under the Trust Fund's coverage.

NOTE: These coordination of benefits provisions do not apply to any individual policy you may have purchased on a non-group basis. COBRA Continuation Coverage under this Fund is NOT regarded as an individual policy.

Miscellaneous Provisions

ERROR
If any information regarding a member is reported incorrectly to the Southern California Lumber Industry Welfare Fund, and the error affects his coverage, the true facts will determine, to what extent, if any, the member was or is eligible for benefits.

ASSIGNMENT
Benefit payments for Hospital, surgical, or medical charges may be assigned by a member i.e., the Fund will pay the Hospital directly and not you. Any other type of assignment is not allowed (see "Benefit Claim and Appeal Procedures" on pages 109 to 128 of this Plan Booklet).

NOT WORKERS' COMPENSATION
The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

BENEFITS EXEMPT FROM ATTACHMENT
To the full extent permitted by law, all rights and benefits under this Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any member or any beneficiary.

BENEFITS PAYABLE AFTER DEATH
If any benefit is payable after your death, payment to the provider of services or any person related to you whom the Trust Fund deems is entitled to the payment will discharge the extent of the Fund's obligation.

Payment of Claims

HOW TO FILE A CLAIM

1. Obtain a claim form from the Administrative Office or your Local Union.

2. File one claim form for each claim.

3. Upon completion of the claim form, attach itemized bills and forward to:

Administrative Office
Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

For claim assistance, write the Administrative Office or call (800) 824-4427.

Post-service claims may also be transmitted by electronic means. Many providers submit their own billing forms either in writing or electronic format. However, it is still your responsibility to ensure the claim is submitted.

All claims must be filed within one year after the date the expense was incurred (see "Benefit Claim and Appeal Procedures" on pages 109 to 128 of this Plan Booklet).

Your Physician or other medical service provider may find out about filing claims electronically by inquiring at www.mapinc.com.

DISCLAIMER:
THE MEDICAL BENEFITS DESCRIBED IN THIS SECTION OF THE BOOKLET ARE NOT INSURED BY ANY CONTRACT OF INSURANCE AND THERE IS NO LIABILITY FOR THE BOARD OF THE TRUSTEES OR ANY INDIVIDUAL OR ENTITY TO PROVIDE PAYMENT OVER AND BEYOND THE AMOUNTS IN THE FUND COLLECTED AND AVAILABLE FOR SUCH PURPOSE.

CONTRIBUTIONS TO THIS PLAN FOR THE PURPOSE OF PROVIDING BENEFITS TO ELIGIBLE INDIVIDUALS ARE MADE BY THE EMPLOYER ON A MONTH-TO-MONTH BASIS ACCORDING TO A COLLECTIVE BARGAINING AGREEMENT. SHOULD COLLECTIVE BARGAINING AGREEMENTS NOT PROVIDE SUFFICIENT FUNDING TO MAINTAIN THE PRESENT BENEFITS, THE TRUSTEES RESERVE THE RIGHT TO CHANGE THE ELIGIBILITY RULES, REDUCE THE BENEFITS, OR ELIMINATE THE PLAN, IN WHOLE OR IN PART, AS MAY BE REQUIRED BY THE CIRCUMSTANCES.

TIME LIMITATION FOR SECTION 502(a) LAWSUIT

A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision. Please see the section of the booklet entitled "Benefit Claim and Appeal Procedures" for the detailed Benefit Claim and Appeal Procedures (beginning on page 109 as amended by Amendments Nos. 9 and 19).

HMO MEDICAL PLAN OPTIONS

The HMO organization selected to provide coverage under the Managed Care Plan is Kaiser Permanente. Kaiser owns its facilities directly and employs its doctors, nurses, and other service providers. If you choose an HMO, you must select and enroll in this option.

Introduction

KAISER PERMANENTE
Kaiser provides many outpatient services as well as all inpatient services at no charge to the participant. A $20 charge is assessed for visits to a Physician's office and other specified physicals and tests. Visits to a doctor for prenatal or well-baby care up to age two are provided with a $5 copayment. The emergency room visit copayment is $50 (waived if admitted as an inpatient). The current yearly out-of-pocket maximum is $1,500 per person and $3,000 per family. These out-of-pocket maximums are subject to change annually. Please contact Kaiser at (800) 731-4661 for updated information.

ENROLLMENT PROCEDURE
Information describing the Kaiser plan is available from the Administrative Office and is also mailed to plan participants each year during the Open Enrollment Period. Copies of the Summary of Benefits and *Evidence of Coverage* booklet is also available from Kaiser directly. If you have any questions or would like to receive more detailed information, please contact Kaiser at (800) 731-4661, or the Administrative Office at (562) 463-5080 or (800) 824-4427 for assistance.

Kaiser Permanente

The following table is a summary of the most frequently utilized benefits and their copayments. Please refer to Kaiser's *Evidence of Coverage* to learn more about what is covered under each benefit, including exclusions and limitations, and additional benefits that are not included in this summary. For example, outpatient prescription drugs are not covered under this plan. NOTE: Kaiser Permanente covers benefits in accord with applicable law (for example, diabetes supplies). A copy of Kaiser's *Evidence of Coverage* is available from the Administrative Office or by calling Kaiser at (800) 731-4661.

SUMMARY OF BENEFITS

BENEFIT	COPAYMENT
Hospital Inpatient Care	
Room and board, including obstetrics	No charge
Physician, surgeon, and surgical services	No charge
Nursing care, anesthesia, x-rays, lab tests and medications	No charge
Outpatient Care	
Primary and specialty care visits for internal medicine, family practice, pediatrics, and gynecology (includes routine and urgent care appointments)	$20 per visit
Well-child preventive care visits (to age 2)	$5 per visit
Scheduled prenatal care and first postpartum visit Family Planning	$5 per visit
Eye exams to provide a prescription for eyeglasses	$20 per visit
Hearing exams	$20 per visit
Outpatient surgery	$20 per visit
Allergy injection visits	$20 per procedure
Allergy testing visits	No charge
Immunizations	$20 per visit No charge
X-rays and lab tests	No charge
Physical, occupational, and speech therapy visits	$20 per visit
Health education for specific conditions:	
Individual visits	$20 per visit
Group visits	No charge
Emergency department visits	$50 per visit (waived if admitted to Hospital)
Mental Health Services	
Inpatient psychiatric care (up to 45 days per calendar year) Outpatient visits:	No charge
Up to a total of 20 individual and/or group therapy visits per calendar year	
Up to 20 additional group therapy visits that meet medical group criteria in the same calendar year	$20 per individual visit $10 per group visit
Note: Visit or day limits do not apply to severe mental illnesses and serious emotional disturbances of children as described in the *Evidence of Coverage*.	
Substance Abuse Services	
Inpatient detoxification	No charge
Outpatient individual therapy visits	$20 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any 5-year period)	$100 per admission
Infertility Services	
Office visits	$20 per visit
Outpatient surgery	$20 per procedure
Outpatient lab tests, x-rays and special procedures	No charge
Hospital inpatient care	No charge

BENEFIT	COPAYMENT
Additional Benefits	
Durable medical equipment in accordance with Kaiser DME formulary	No charge
External prosthetic and orthotic devices	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Home health care (up to 100 two-hour visits per calendar year)	No charge
Hospice care	No charge
Ambulance services	No charge
Coordination of benefits	Included

ANNUAL AND LIFETIME MAXIMUMS AND OTHER BENEFIT LIMITS
Annual out-of-pocket maximums are $1,500 per member and $3,000 per family. Kaiser has no deductibles or annual or lifetime dollar maximums. Some benefits have annual visit or day limitations (e.g., skilled nursing facility benefits).

Out-of-pocket maximums apply only to basic health services such as Hospital care and physical, speech and occupational therapies. Supplemental benefits such as durable medical equipment, prosthetics and orthotics, hearing aids, and vision do not apply to the out-of-pocket copayment maximums.

How do I apply the annual out-of-pocket maximum?
When you pay a copayment or coinsurance for these services, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, call Kaiser's Member Service Call Center at (800) 464-4000 to find out where to submit your receipts. When you submit your receipts, you will be given a document to show that you do not have to pay any more copayments or coinsurance through the end of the calendar year.

USE OF NETWORK PROVIDERS AND COMPOSITION OF NETWORK
Kaiser Permanente provides services directly to its members through an integrated medical care program. Kaiser maintains a network of providers and facilities that work together to provide its members with quality care. Kaiser provides covered services to members using Kaiser providers located in your Kaiser service area. Except for out-of-area emergency and urgent care or other care authorized by Kaiser, you must receive all covered care from Kaiser providers inside your service area.

Members may select from any of Kaiser Permanente's primary care Physicians (PCPs) and can receive care at any Kaiser Permanente medical facility. At their discretion, members may also select a new Physician at any time.

CONDITIONS OR LIMITS ON SELECTION OF PRIMARY CARE PROVIDERS AND SPECIALISTS
Although some individual Physicians may not be accepting new patients (their panel is full), there are always primary care Physicians within those medical groups who are accepting new members or members who want to change doctors. Once a doctor has been designated as a member's personal Physician, the member can make appointments with that doctor whether or not the doctor is accepting new patients (their panel is full). Additionally, family members of current patients may be assigned to a Physician whose panel is full with the consent of the Physician. Controlling

the size of Physician panels allows for more effective preventative care, increases member and provider satisfaction, as well as improves the overall quality of care. The decision to close a given Physician's panel is made by the department chief at each medical facility. Panel status is updated on a regular basis.

PROVIDER LISTINGS

Provider directories are given to all new members to aid them in their selection of a personal Physician. In addition, each medical center maintains Physician information that members can access to verify licensure, medical school graduation, residency and/or fellowship training, and board certification. Physician information can also be obtained by calling the Member Services Call Center at **(800) 464-4000**. All new members also receive a copy of the Guidebook to Kaiser Permanente Services, which contains maps and directions to medical offices, Hospitals, and pharmacies, along with department phone numbers and listings of the services offered at each facility.

The Kaiser Permanente web site, **http://www.kaiserpermanente.org** has an online provider directory that displays background information about each listed Physician, including his or her specialty, location, education, residency, board certification, gender, date hired, and languages spoken. The directory also contains links to California locations and services for maps and directions to medical offices, Hospitals, and pharmacies, along with department phone numbers and listings of the services offered at each Kaiser Permanente facility.

CONDITIONS OR LIMITS APPLICABLE TO EMERGENCY CARE

For member safety and health, Kaiser Permanente covers emergency care administered by Kaiser providers and non-Kaiser providers anywhere in the world. Emergency care is defined as medically necessary ambulance transportation and the evaluation of a member by appropriate medical personnel, to determine if an emergency medical condition exists. If an emergency medical condition does exist, coverage also includes medically necessary care, treatment, and surgery required to clinically stabilize the member's emergency medical condition within the capabilities of the facility.

An emergency medical condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following: serious jeopardy to your health, serious impairment to your bodily functions, serious dysfunction of any bodily organ or part or "active labor," which means a labor when there is inadequate time for safe transfer to a Kaiser Hospital or designated Hospital before delivery or if transfer poses a threat to the health and safety of the member or unborn child.

Emergency care is available at Kaiser Hospital emergency departments listed in the Kaiser booklet entitled "Your Guidebook." For ease and continuity of care, you are encouraged to go to a Kaiser Hospital emergency department, but only if it is reasonable to do so, considering your condition or symptoms.

URGENT CARE

An urgent care need is one that requires prompt medical attention, but is not an emergency medical condition. If members think they may need urgent care, they need to call the appropriate appointment or advice nurse telephone number for services at a plan facility.

When a member is temporarily outside of Kaiser Permanente's service area and has an urgent care need due to an unforeseen illness or injury, medically necessary services by a non-Kaiser provider are covered. Kaiser Permanente does require that rendered services be necessary to prevent serious deterioration of the member's health and could not be delayed until return to a Kaiser Permanente service area.

ADDITIONAL COVERAGE LIMITATIONS

Members need to request authorization for post-stabilization care before care is administered by a non-Kaiser provider, if it is reasonably possible to do so (otherwise, call as soon as reasonably possible).

Members or persons representing a member must notify Kaiser Permanente that they have been admitted to a non-Kaiser Hospital within 24 hours of any admission or as soon as reasonably possible. Kaiser Permanente will decide whether to make arrangements for necessary continued care at the present facility, or to transfer the member to a designated facility. If a member doesn't notify Kaiser personnel as soon as reasonably possible, services administered after a member is clinically stable will not be covered.

Kaiser Permanente understands that extraordinary circumstances can delay a member's ability to call a Kaiser representative, for example if the member is unconscious or is a young child without a parent or guardian. In these cases, the member must call a Kaiser Permanente representative as soon as it is reasonably possible. Please keep in mind that anyone can call in a member's interest and notify Kaiser personnel. If members don't call and notify Kaiser personnel when it becomes possible to do so, that member will be financially responsible for the cost of the unauthorized services received after the member was determined to be clinically stable.

PREAUTHORIZATION OR UTILIZATION REVIEW

Unlike some managed care organizations or insurance companies where Physician decisions or referrals are reviewed by health plan administrators or clerks, Kaiser Permanente medical group Physicians are solely responsible for making all medical decisions and do not require approval, preauthorization, or review of medical decisions from Kaiser Health Plan administrators. When a service is not covered because it is a supplemental benefit not purchased by the Fund, Kaiser Permanente provides access to the benefit at reduced member rates.

If there are any discrepancies between benefits and explanation of coverage included in this Summary Plan Description and Kaiser's *Evidence of Coverage*, the *Evidence of Coverage* will prevail.

DRUG COVERAGE

Outpatient prescription drugs are not covered under the Kaiser plan. The Trust Fund offers prescription drug coverage through a self-insured benefit program. Please see the "Prescription Drug Benefits" section on pages 88 to 96 of this Plan Booklet for details.

COVERAGE FOR MEDICAL TESTS, DEVICES AND PROCEDURES

Medical tests, devices, and procedures are covered if all of the following conditions are satisfied:

1. The services are medically necessary;

2. The services are provided, prescribed, authorized, or directed by a Kaiser Physician except where specifically noted to the contrary in the Kaiser *Evidence of Coverage*; and

3. The services are received from a Kaiser provider inside the service area, except where specifically noted to the contrary in the Kaiser *Evidence of Coverage*.

There may be a copayment for some of these services.

COVERAGE FOR OUT-OF-NETWORK SERVICES

Non-Emergency Health Care

The Kaiser Foundation Health Plan contracts with Kaiser Foundation Hospitals and the Permanente medical groups to provide the Hospital and medical services required to meet the covered health benefits of their members. When a referral to a specialist is deemed medically necessary, a primary care Physician refers the member to the appropriate specialty department within Kaiser's medical groups. If the Medical Group determines that there isn't a Plan Physician who is an appropriately, qualified medical professional for your condition, the Medical Group will authorize a referral to a Non-Plan Physician for a Medically Necessary second opinion.

Emergency Health Care

Members are covered for unexpected illness or injury at a non-Kaiser Permanente facility under the terms of the out-of-plan emergency services benefit as outlined in the Kaiser *Evidence of Coverage*. For a definition of what constitutes an emergency, see the "Conditions or Limits Applicable to Emergency Care" section on page 54 of this Plan Booklet.

Members who receive emergency health care services at a non-Kaiser Hospital or facility outside of the Kaiser Permanente service area may submit a completed claim form or bills for review and payment to the Claims Administration Department. The procedures for completing this process are described in the Kaiser *Evidence of Coverage* booklet and also in the *Travel Guide* which can be provided to Kaiser members traveling outside their normal service area. You can request a claim form by calling the Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370).

LIMITATIONS AND EXCLUSIONS

1. Physical examinations and other services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or licensing, or (c) on court order or required for parole or probation. This exclusion does not apply if a Kaiser Physician determines that the services are medically necessary.

2. Chiropractic Services - Chiropractic services and the services of a chiropractor.

3. Conception by artificial means - Except for artificial insemination covered under "Infertility Services" section of the Kaiser *Evidence of Coverage,* all other services related to conception by artificial means, such as ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

4. Cosmetic Services - Services that are intended primarily to change or maintain your appearance, except for services covered under the "Reconstructive Surgery" section of the Kaiser *Evidence of Coverage* and prostheses needed after a mastectomy covered under the "Prosthetic and Orthotic Devices" section of the Kaiser *Evidence of Coverage*.

5. Custodial Care - Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to services covered under the "Hospice Care" section of the Kaiser *Evidence of Coverage*.

6. Dental Care - Dental care and dental x-rays, such as dental service following an accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for services covered under the "Dental Services for Radiation Treatment and Dental Anesthesia" section of the Kaiser *Evidence of Coverage*.

7. Disposable Supplies - Disposable supplies for home use, such as diapers, under pads, and other incontinence supplies, bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages. This exclusion does not apply to disposable supplies covered under the "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care", "Ostomy and Urological Supplies", and "Outpatient Self-Administered Drugs and Diabetes Supplies" sections in the Kaiser *Evidence of Coverage*.

8. Experimental or Investigational Services - A service is experimental or investigational if Kaiser, in consultation with your medical group, determines that one of the following is true: (a) generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients) or (b) it requires government approval that has not been obtained when the service is to be provided. This exclusion does not apply to services covered under the "Services Associated with Clinical Trials" section in the Kaiser *Evidence of Coverage*. Please refer to the "Dispute Resolution" section below for information about independent medical review related to denied requests for experimental or investigational services.

9. Eye Surgery, Eyeglasses and Contact Lenses, and Contact Lens Eye Examinations Services related to eye surgery or orthokeratologic services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism; eyeglass lenses and frames; contact lenses, including fitting and dispensing; eye examinations for the purpose of obtaining or maintaining contact lenses; low vision devices. This exclusion does not apply to contact

lenses to treat aniridia or aphakia covered under the "Outpatient Care" section in the Kaiser *Evidence of Coverage*.

10. Hair Loss or Growth Treatment - Services for the promotion, prevention, or other treatment of hair loss or hair growth.

11. Hearing Aids - Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid. This exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered under the "Prosthetic and Orthodontic Devices" section in the Kaiser *Evidence of Coverage*.

12. Intermediate Care - Care in a licensed intermediate care facility. This exclusion does not apply to services covered under the "Hospice Care" section in the Kaiser *Evidence of Coverage*.

13. Routine Foot Care Services - Routine foot care services that are not medically necessary.

14. Services Related to a Non-Covered Service - When a service is not covered, all services related to the non-covered service are excluded, except for services that Kaiser would otherwise cover to treat complications of the non-covered service.

15. Speech Therapy - Speech therapy services to treat social, behavioral, or cognitive delays in speech or language development unless medically necessary.

16. Surrogacy - Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered services provided to a member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to the Kaiser *Evidence of Coverage.*

17. Travel and Lodging Expenses - Travel and lodging expenses, except that in some situations if the Kaiser medical group refers you to a non-Kaiser provider as described in the Kaiser *Evidence of Coverage*, Kaiser may pay certain expenses that it preauthorizes in accordance to Kaiser's travel and lodging guidelines. A copy of Kaiser's travel and lodging guidelines are available from Kaiser's Member Service Call Center.

CLAIMS AND APPEALS PROCEDURES

Requests for Payment

Emergency, Post-Stabilization or Out-of-Area Urgent Care

If you receive emergency care, post-stabilization, or out-of-area urgent care from a non-Kaiser provider as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section of your Kaiser Permanente *Evidence of Coverage*, you must pay for the services and file a claim if you want Kaiser Permanente to pay for the services, unless the non-Kaiser provider agrees to bill Kaiser. Also, if you receive services from a Kaiser provider that are prescribed by a non-Kaiser provider in conjunction with covered emergency, post- stabilization,

and out-of-area urgent care, you may be required to pay for the services and file a claim. Kaiser will reduce any payment it makes to you or the non-Kaiser provider by the applicable cost sharing.

Kaiser Permanente will send you its written decision within 30 days after it receives the claim from you or the non-Kaiser provider unless it notifies you, within that initial 30 days, that it needs additional information from you or the non-Kaiser provider. Kaiser must receive the additional information within 45 days of its request in order for the information to be considered in its decision. Kaiser will send you its written decision within 15 days of receiving the additional information. However, if Kaiser doesn't receive the additional information within 45 days of its request, it will send you its written decision no later than 90 days from the date of your initial request for payment.

If your claim is denied in whole or in part, Kaiser Permanente will send you a written decision that fully explains why it was denied and how you can file a grievance.

How to File a Claim
To file a claim, this is what you need to do:

As soon as possible, request a claim form by calling the Member Service Call Center toll free at (800) 464-4000 (TTY (800) 777-1370), 7 a.m. to 7 p.m., seven days a week. A Kaiser representative will assist you if you need help completing the claim form.

- If you have paid for the services, you must send Kaiser the completed claim form for reimbursement. Please attach any bills and receipts from the non-Kaiser provider.

- To request that a non-Kaiser provider be paid for services, you must send the completed claim form and include any bills from the non-Kaiser provider. If the non-Kaiser provider states that they will submit the claim, you are still responsible for making sure that Kaiser Permanente receives everything needed to process the request for payment. If you later receive any bills from the non-Kaiser provider for covered services other than your cost sharing amount, you should call the Member Service Call Center toll free (800) 390-3510 (TTY (800) 777-1370), 7 a.m. to 7 p.m., seven days a week for assistance.

- You must complete and return to Kaiser Permanente any information requested to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, Kaiser may require documents such as travel documents or original travel tickets to validate your claim.

- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information requested should also be mailed to this address:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

Other Services

To request payment for services you believe should be covered, other than the services described above, you must submit a written request to your local Member Services Department. Please attach any bills and receipts if you have paid any bills.

Kaiser Permanente will send you a written decision within 30 days unless you are notified, within that initial 30 days, that additional information is needed from you or the non-Kaiser provider. Kaiser Permanente must receive the additional information within 45 days of the request in order for the information to be considered in the decision. Kaiser Permanente will send you the written decision within 15 days of receiving the additional information. However, if Kaiser Permanente doesn't receive the additional information within 45 days of the request, Kaiser Permanente will send you a written decision no later than 90 days from the date of your initial request for payment.

If your request is denied in whole or in part, the written decision will fully explain why Kaiser Permanente denied it and how you can file a grievance.

Standard Decision
If you have received a written denial of services from the medical group or a "Notice of Non-Coverage" and you want to request that Kaiser Permanente cover the services, you must file a grievance as described in the "Dispute Resolution" section within 180 days of the date you received the denial.

If you haven't received a written denial of services, you may make a request for services orally or in writing to your local Member Services Department at a Kaiser Facility. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days of receipt of the additional information. If you don't supply the additional information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services. If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

If you believe Kaiser Permanente should cover a medically necessary service that is not a covered benefit under your Kaiser Permanente *Evidence of Coverage*, you may file a grievance as described in the "Dispute Resolution" section.

Expedited Decision
You or your Physician may make an oral or written request that Kaiser Permanente expedite the decision about your request for services if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. Kaiser Permanente will inform you of the decision within 72 hours (orally or in writing).

If the request is for a continuation of an expiring course of treatment and you make the request at least 24 hours before the treatment expires, Kaiser Permanente will inform you of the decision within 24 hours.

You or your Physician must request an expedited decision in one of the following ways and you must specifically state that you want an "expedited decision":

- Call Kaiser's Expedited Review Unit toll free at (888) 987-7247 (TTY 800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5:00 p.m. After hours you may leave a message and a representative will return your call the next business day.

- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

- Fax your written request to Kaiser's Expedited Review Unit at (888) 987-2252.

- Deliver your request in person to your local Member Services Department at a Kaiser Facility.

If Kaiser Permanente denies your request for an expedited decision, you will be notified and Kaiser Permanente will respond to your request for coverage as described under the "Standard Decision" section above. If Kaiser Permanente denies your request for coverage in whole or in part, a written decision will fully explain why it was denied and how you can file a grievance.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the Department of Managed Health Care (DMHC) directly at any time without first filing a grievance with Kaiser Permanente.

DISPUTE RESOLUTION

Grievances

Kaiser Permanente is committed to providing you with quality care and with a timely response to your concerns. Member Service representatives are available to discuss your concerns at most Kaiser Facilities or you can call the Member Service Call Center toll-free at (800) 464-4000 (TTY (800) 777-1370) 7 a.m. to 7 p.m., seven days a week.

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

- To a Member Service representative at your local Member Services Department at a Kaiser Facility, or by calling the Member Service Call Center toll-free at (800) 464-4000 (TTY (800) 777-1370).

- Through Kaiser's web site at **www.kp.org**.

- To the following location for claims described under "Emergency, Post-Stabilization or Out-of-Area Urgent Care" in the "Requests for Payment" section above:

  Kaiser Permanente
  Special Services Unit
  P.O. Box 7136
  Pasadena, CA 91109

Kaiser Permanente will send you a confirmation letter within five days of receipt of your grievance. Kaiser Permanente will send you a written decision within 30 days after it receives your grievance. If your grievance is denied in whole or in part, the written decision will fully explain why it was denied and additional dispute resolution options. Note: If Kaiser resolves your issue to your satisfaction by the end of the next business day after it receives your grievance and a Member Services representative notifies you orally about Kaiser's decision, Kaiser will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a service is medically necessary, or an experimental or investigational treatment.

Expedited Grievance
You or your Physician may make an oral or written request that Kaiser Permanente expedite a decision about your grievance if it involves imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. Kaiser Permanente will inform you of the decision within 72 hours (orally or in writing).

Kaiser Permanente will also expedite a decision if the request is for a continuation of an expiring course of treatment.

You or your Physician must request an expedited decision in one of the following ways and you must specifically state that you want an "expedited decision":

- Call Kaiser's Expedited Review Unit toll free at (888) 987-7247 (TTY 800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5:00 p.m. After hours you may leave a message and a representative will return your call the next business day.

- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

- Fax your written request to Kaiser's Expedited Review Unit at (888) 987-2252.

- Deliver your request in person to your local Member Services Department at a Kaiser Facility.

If Kaiser Permanente denies your request for an expedited decision, you will be notified and Kaiser Permanente will respond to your grievance within 30 days. If your grievance is denied in whole or in part, the written decision will fully explain why it was denied and additional dispute resolution options.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the Department of Managed Health Care (DMHC) directly at any time without first filing a grievance with Kaiser Permanente.

Supporting Documents
It is helpful for you to include any information that clarifies or supports your position. You may want to include supporting information with your grievance, such as medical records or Physician opinions. When appropriate, Kaiser Permanente will request medical records from Kaiser providers on your behalf. If you have consulted with a non-Kaiser provider and are unable to provide copies of relevant medical records, Kaiser Permanente will contact the provider to request a copy of your medical records. Kaiser Permanente will ask you to send or fax a written authorization to Kaiser so that it may request your records. If Kaiser Permanente does not receive the information requested in a timely fashion, Kaiser Permanente will make a decision based on the information already received.

Who May File
The following persons may file a grievance:

- You may file for yourself.

- You may appoint someone as your authorized representative by completing Kaiser's authorization form. Authorization forms are available from your local Member Services Department at a Kaiser Facility or by calling the Member Service Call Center. Your completed authorization form must accompany the grievance.

- You may file for your dependent children, except that your child will have to appoint you as his or her authorized representative if they have the legal right to control release of information that is relevant to the grievance.

- You may file for your ward if you are a court-appointed guardian.

- You may file for your conservatee if you are a court-appointed conservator.

- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law.

- Your Physician may request an expedited grievance as described under "Expedited Grievance" in the "Dispute Resolution" section above.

DMHC Complaints
The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Kaiser Permanente health plan, you should first telephone Kaiser Permanente at (800) 464-4000 (TTY users call 1-800-777-1370) and use Kaiser's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Kaiser, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Kaiser related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll free telephone number (888) HMO-2219 and a TDD line (877) 688-9891 for the hearing and speech impaired. The Department's internet web site **www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

Independent Medical Review (IMR)
If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against Kaiser Permanente.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
    - You have a recommendation from a provider requesting medically necessary services.
    - You have received emergency care or urgent care from a provider who determined the services to be medically necessary.
    - You have been seen by a Kaiser provider for the diagnosis or treatment of your medical condition.
    - Your request for payment or services has been denied, modified, or delayed based in whole or in part on a decision that the services are not medically necessary.
    - You have filed a grievance and Kaiser Permanente has denied it or has not made a decision about your grievance within 30 days (or three days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with Kaiser Permanente in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function.

You may also qualify for IMR if the service you requested has been denied on the basis that it is experimental or investigational as described under the "Experimental or Investigational Denials" section below.

If DMHC determines that your case is eligible for independent medical review, it will ask Kaiser Permanente to send your case to the DMHC's independent medical review organization. The DMHC will promptly notify you of its decision after it receives the independent medical review organization's determination. If the decision is in your favor, Kaiser Permanente will contact you to arrange for the service or payment.

Experimental or Investigational Denials
If Kaiser Permanente denies a service because it is experimental or investigational, Kaiser will send you its written explanation within five days of making its decision. Kaiser will explain why it denied the service and will provide additional dispute resolution options. Also, Kaiser will provide information about your right to request an independent medical review if Kaiser had the following information when it made its decision:

- Your treating Physician provided Kaiser a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy that Kaiser covers than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

- If your treating Physician is a Kaiser Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Kaiser Physician in certifying his or her recommendation.

- You (or your non-Kaiser Physician who is a licensed, and either a board-certified or board-eligible, Physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The Physician's certification included a statement of the evidence relied upon by the Physician in certifying his or her recommendation. Kaiser Permanente does not cover the services of the non-Kaiser provider.

Note: You can request an IMR for experimental or investigational denials at any time without first filing a grievance with Kaiser Permanente.

Binding Arbitration
For all claims subject to this "Binding Arbitration" section, both claimants and respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding

Arbitration" section applies to claims asserted by Kaiser Permanente parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of the current Kaiser Permanente *Evidence of Coverage*. Such retroactive application shall be binding only on the Kaiser Permanente parties.

Scope of Arbitration
Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to the Kaiser Permanente *Evidence of Coverage* or a member party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or Hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services, irrespective of the legal theories upon which the claim is asserted.

- The claim is asserted by one or more member parties against one or more Kaiser Permanente parties or by one or more Kaiser Permanente parties against one or more member parties.

- The claim is *not* within the jurisdiction of the small claims court.

- If the member's group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice.

As referred to in this "Binding Arbitration" section, "member parties" include:

- A member

- A member's heir, relative or personal representative

- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente parties" include:

- Kaiser Foundation Health Plan, Inc. (Health Plan)

- Kaiser Foundation Hospitals (KFH)

- KP Cal, LLC (KP Cal)

- The Permanente Medical Group, Inc. (TPMG)
- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any KFH, TPMG, or SCPMG Physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more member parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a member party or a Kaiser Permanente party who asserts a claim as described above. "Respondent" refers to a member party or a Kaiser Permanente party against whom a claim is asserted.

Initiating Arbitration
Claimants shall initiate arbitration by serving a demand for arbitration. The demand for arbitration shall include the basis of the claim against the respondents; the amount of damages the claimants seek in the arbitration; the names, addresses, and telephone numbers of the claimants and their attorney, if any; and the names of all respondents. Claimants shall include all claims against respondents that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Serving Demand for Arbitration
Health Plan, KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC shall be served with a demand for arbitration by mailing the demand for arbitration addressed to that respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 East Walnut Street
Pasadena, CA 91188

Service on that respondent shall be deemed completed when received. All other respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee
The claimants shall pay a single, non-refundable, filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the demand for arbitration or the number of claimants or respondents named in the demand for arbitration.

Any claimant who claims extreme hardship may request that the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Call Center toll free at (800) 464-4000 (TTY (800) 777-1370), 7 a.m. to 7 p.m., seven days a week.

Number of Arbitrators
The number of arbitrators may affect the claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the demand for arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and a neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the demand for arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all claimants and one jointly appointed by all respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrators' Fees and Expenses
Kaiser Foundation Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the claimants and one-half by the respondents.

If the parties select party arbitrators, claimants shall be responsible for paying the fees and expenses of their party arbitrator and respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs
Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure
Arbitrations shall be conducted according to Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from the Member Service Call Center by calling toll free at (800) 464-4000 (TTY (800) 777-1370), 7 a.m. to 7 p.m., seven days a week.

General Provisions

A claim shall be waived and forever barred if (1) on the date the demand for arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the respondents served by the applicable statute of limitations, or (2) claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the demand for arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section.

DENTAL PLAN BENEFITS

IMPORTANT
DENTAL BENEFITS ARE NOT AVAILABLE FOR ALL PARTICIPANTS
Since benefits are determined by the Collective Bargaining Agreement, please contact the Administrative Office to see if you qualify for this benefit.

Introduction

If you are eligible for the dental plan benefit, the Trust Fund provides two options for dental coverage under the Managed Care Plan: the Scheduled Dental Plan and a prepaid dental plan. DeltaCare USA is the prepaid dental plan provider.

Choice of Plans

NOTE: You must enroll in a plan. This is your responsibility.

Your dental plan choices are:
1. Scheduled Dental Plan
2. DeltaCare USA Dental Plan (prepaid plan)

Enrollment

INITIAL ENROLLMENT
Members becoming eligible for dental benefits the first time must complete an Enrollment and Plan Selection Form designating the dental plan in which they wish to enroll within 90 days of the date they first become eligible. IF NO CHOICE IS MADE OR THE ENROLLMENT FORM IS NOT RETURNED, THE MEMBER WILL AUTOMATICALLY BE PLACED IN THE SCHEDULED DENTAL PLAN. Once you have made a choice of plans, you and your dependents will remain covered by that plan as long as you remain eligible, unless you fill out a choice card changing your original selection during the Managed Care Plan's Annual Open Enrollment period. Please, however, see the section entitled "HIPAA Special Enrollment Rights" on page 16 of this Plan Booklet.

ANNUAL OPEN ENROLLMENT
If you are eligible for the dental plan benefit, you will have the opportunity to change your plan selection during the Managed Care Plan's Annual Open Enrollment period. During the month of November of each year you may change your plan selection for the 12 months commencing the following January 1. Information on the plans available to you is mailed in November of each year. If you wish to make a change in your plan selection, it is your responsibility to complete an Enrollment and Plan Selection Form and submit it to the Administrative Office.

Once you have made your choice, you will remain in that plan, even though you may change employers, except that if you return to work after you are not reported to the Fund for a period of six months, it will again be necessary for you to enroll in the plan of your choice.

If you have any questions regarding your coverage or if you have not received an Enrollment and Plan Selection Form, please call the Administrative Office at (562) 463-5080 or (800) 824-4427.

Scheduled Dental Plan

The following benefits apply only if dental contributions are paid on your behalf and if you have not elected to be covered by the DeltaCare USA Dental Plan.

The Scheduled Dental Plan is provided directly by the Trust Fund under a self-insured dental plan. You may use the dentist of your choice. You will be reimbursed for covered dental charges in accordance with the Summary of Dental Benefits set out below. You will be responsible for the difference between the Fund's payment and the dentist's charges.

Covered Charges means the Trust Fund will reimburse the lesser of the dentist's charge or the maximum shown in the Summary of Dental Benefits. The reimbursement will be based on the percentage shown in the Summary of Dental Benefits. Limited orthodontia is covered under this Plan. An expense or charge is deemed to be incurred on the date on which the service or supply is rendered or obtained.

Benefits are payable for Covered Charges incurred while eligible for benefits. The Plan pays benefits according to a schedule of maximum amounts, payable at 80% or 50%. The percentage payable is based on the type of dental service provided.

SUMMARY OF DENTAL BENEFITS

BENEFITS	SCHEDULED DENTAL PLAN COVERAGES
Lifetime Maximum (except Orthodontics)	None
Calendar Year Maximum ***** Please note that pediatric (ages 0 through 18) oral services have no annual dollar maximums. Therefore, while applicable visit/treatment limitations continue to apply to children ages 0 through 18, any scheduled maximum amounts listed in Part I below will not apply if a visit/treatment limitation is provided. In those cases (i.e., prophylaxis, topical application of fluoride), 80% of the dentist's rate charged will be reimbursed, as set out in the schedule.	$1,500 *
Deductible	None
Out-of-Pocket Maximum * Please note that expenses paid by you for covered pediatric (ages 0 through 18) oral services through the Scheduled Dental Plan will count towards the per-person or per-family Out-of-Pocket Maximum under the Indemnity Medical Plan, as applicable (if you are enrolled in both the Indemnity Medical Plan and the Scheduled Dental Plan).	None

BENEFITS	SCHEDULED DENTAL PLAN COVERAGES
PART I – DIAGNOSTIC AND PREVENTIVE DENTISTRY	
Visits and Examinations	**Payable at 80% of:**
Initial exam	$ 29.40
Emergency palliative treatment	$ 30.40
Special consultation (allowance only for case presentation by a specialist after diagnostic procedures have been performed by a general dentist)	$ 57.00
Prophylaxis (maximum one treatment in each 6-month period beginning on January 1 and July 1 of each year) Children to age 14 Adults and children age 14 and over	 $ 33.60 $ 42.00
Topical application of fluoride (allowance for concurrent prophylaxis is additional; maximum one treatment per calendar per year)	$ 46.20
Roentgenology and Pathology	**Payable at 80% of:**
X-rays Single film Each additional film on same day (up to 5 films) Full mouth x-rays Intra-Oral, occlusal view, maxillary or mandibular, each	 $ 12.60 $ 8.40 $ 58.40 $ 21.00
Biopsy of oral hard tissue	$114.00
Microscopic examination	$31.50
Biopsy of oral soft tissue	$83.60
PART II – RESTORATIVE DENTISTRY AND ORAL SURGERY	
Extractions	**Payable at 80% of:**
Single, uncomplicated (including routine post-operative visits)	$ 57.00
Each additional tooth on same day (including routine post-operative visits)	$ 53.20
Surgical removal of erupted tooth (involving tissue flap, bone removal, or sutures)	$95.00
Impacted Teeth	**Payable at 80% of:**
Removal of tooth (soft tissue)	$114.00
Removal of tooth (partially bony)	$152.00
Removal of tooth (completely bony)	$174.80

BENEFITS	SCHEDULED DENTAL PLAN COVERAGES
Restorative Dentistry	**Payable at 80% of (except Gold restorations):**
Amalgam Restorations – Primary Teeth	
Cavities involving one tooth surface	$ 38.00
Cavities involving two tooth surfaces	$ 49.40
Cavities involving three or more tooth surfaces	$ 60.80
Amalgam Restorations – Permanent Teeth	
Cavities involving one tooth surface	$ 45.60
Cavities involving two tooth surfaces	$ 57.00
Cavities involving three or more tooth surfaces	$ 68.40
Silicate, Porcelain Synthetic, and Acrylic (Plastic Restorations)	
Silicate cement filling	$ 45.60
Acrylic, plastic, or composite resin	$ 49.40
Gold Restorations	**Payable at 50% of:**
Inlay one surface	$324.00
Inlay two surfaces	$360.00
Inlay three or more surfaces	$396.00
Onlay, additional – per tooth	$ 54.00
Endodontics	**Payable at 80% of:**
Pulp cap	$ 22.80
Therapeutic pulpotomy	$ 45.60
Root Canals	
Single root canal therapy	$266.00
Bi-root canal therapy	$323.00
Tri-root canal therapy	$418.00
Periodontics	**Payable at 80% of:**
Subgingival curettage, root planing	$ 95.00
Osseous surgery, per quadrant	$456.00
Gingivectomy, per quadrant	$266.00
Alveolar or Gingival Reconstruction	**Payable at 80% of:**
Alveoloplasty in conjunction with extractions per quadrant	$114.00
Alveoloplasty not in conjunction with extractions per quadrant	$152.00
Cysts and Neoplasms	**Payable at 80% of:**
Excision of small cyst (less than ½ inch)	$114.00
Excision of large cyst (½ inch or more)	$228.00
Intra-oral incision and drainage of abscess	$ 68.40

BENEFITS	SCHEDULED DENTAL PLAN COVERAGES
Miscellaneous	**Payable at 80% of:**
Therapeutic drug injection	$ 22.80
General anesthesia (out of Hospital)	$ 95.00
Repairs, adjustments, and additions to dentures	
Repairs – broken denture	$ 64.60
Adjustments (more than 6 months following installation)	$ 30.40
Adding teeth to partial denture	
First tooth	$ 83.60
Each additional tooth or clasp	$ 68.40
PART III – REPLACEMENT OF NATURAL TEETH	
Crowns	**Payable at 50% of:**
Acrylic	$198.00
Acrylic with metal	$396.00
Porcelain	$432.00
Porcelain with metal	$450.00
Gold (full)	$424.80
Stainless Steel	$ 72.00
Fixed Bridges	**Payable at 50% of:**
Abutments – *See Crowns and Gold Restorations*	
Pontics	
Cast high noble metal	$424.80
Porcelain fused to high noble metal	$432.00
Resin with metal	$396.00
Recementation	**Payable at 80% of:**
Bridge	$ 57.00
Bridge repair – allowance based on time and laboratory charges	B/R
Prosthetics	**Payable at 50% of:**
Complete denture (upper or lower)	$676.50
Removable partial denture	
Acrylic upper or lower including any teeth, clasps and rests	$820.00
Upper or lower partial cast base (including teeth, clasps, and rests)	$1,066.00
Stayplate	$246.00
Removable unilateral partial denture, per unit	$164.00
Denture reline	
Office reline	$152.00
Laboratory reline	$190.00
Space Maintainers	**Payable at 50% of:**
Fixed space maintainer	$210.00

BENEFITS	SCHEDULED DENTAL PLAN COVERAGES
PART IV – OROTHODONTICS	
Complete Orthodontic Treatment Plan (Lifetime maximum of $1,500 for eligible members or dependents)	**Payable at 50% of:** $3,000.00

ORTHODONTIC BENEFIT
Covered orthodontic treatment includes the charges for services and supplies in connection with a complete orthodontic treatment plan to correct malposed teeth, provided the dentist has diagnosed one of the following conditions:

1. The existence of extreme bucco-lingual version of the teeth, either unilateral or bilateral.

2. A protrusion of the maxillary teeth of more than 4 mm.

3. A protrusive or retrusive relation of the maxillary or mandibular arch of at least one cuspid.

4. An arch length discrepancy of at least 4 mm.

Benefits will be considered and then based on the submission of an itemized bill following the banding date for all services related to the orthodontic treatment plan. The incurred date of services for Covered Orthodontic Charge is the banding date. Benefits are payable for orthodontic expenses only if a participant and dependents are eligible and enrolled in the Scheduled Dental Plan on the banding date.

LIMITATIONS AND EXCLUSIONS
The Scheduled Dental Plan does not pay expenses for:

1. Payment made under the Trust Fund other than under the Dental Plan.

2. Any dental procedure performed solely for cosmetic reasons.

3. Orthodontic treatment except as described above.

4. Replacement of an existing denture which, in the opinion of the attending dentist, is or can be made satisfactory.

5. Replacement of a prosthesis for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless (a) the replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth, (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and is being replaced by a permanent prosthesis, (c) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury, or (d) the contour of the mouth, as a result of injury or illness, has so changed that the prosthesis can no longer be made to fit satisfactorily.

6. Replacement of a lost or stolen appliance.

7. Any supplies or services for which you are not required to pay, which are furnished by or payable under any plan or law of any government or furnished by a county or municipal Hospital where there is no legal requirement to pay for such supplies or services.

8. Any disability covered by a workers' compensation or occupational disease law.

9. Illness or injury arising from or sustained in the course of any occupation or employment for compensation, profit or gain.

10. Treatment for an illness or injury which was a result of participation in or consequence of the commission of a felony or misdemeanor.

11. Illness or injury arising from or sustained in the course of any criminal activity including a riot.

12. Services for which you are not required to pay, if you did not have this coverage (you must also have been billed for the treatment, service, or supply).

13. Treatment for any bodily injury or disease that results from employment or occupation for compensation.

14. Treatment by one who normally resides in the member's home or who is the wife, husband, child, brother, sister, or parent of either the member or his spouse.

15. Treatment for injuries or illness caused through the act or omission of a third party, where you are pursuing or you intend to pursue a claim or lawsuit against a third party.

16. Experimental or investigational treatment of an injury or illness.

DEFINITIONS

Covered Charge means the expense incurred for treatment received by the member from a dentist, which is Usual, Customary and Reasonable (UCR), in the geographic area where treatment is rendered, and which is medically necessary. However, the amount considered as "Covered Charges" will not exceed the maximum amount on the Summary of Benefits. An expense or charge is determined to be incurred on the date the service is rendered.

Covered Orthodontic Charge means an expense incurred by an eligible participant for medically necessary orthodontic treatment. The amount considered as "Covered Orthodontic Charge" will include the total cost of the orthodontic treatment plan and the incurred date of services will be the date the banding of teeth is completed. Benefits are limited to a lifetime maximum of $1,500 while otherwise eligible.

Plan Year means the period of twelve months beginning on January 1 of each year.

Prosthesis means any crown or any fixed or removable denture.

COORDINATION OF BENEFITS

The benefits payable for covered charges incurred will be coordinated with any other group insurance you or your dependents may have.

Coordination means that benefits are paid so that no more than 100% of Reasonable and Customary expenses will be covered under the combined benefits from all the following plans: (1) this Plan, (2) any other group, blanket or franchise insurance coverage, (3) group practice and other group prepayment coverage, (4) group service plans, (5) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, (6) any coverage provided by governmental programs, and (7) any coverage required or provided by statute.

The Fund may obtain or release any information necessary to carry out these provisions, subject to the HIPAA privacy regulations. You must declare your coverage under other plans. The Fund can recover from the member amounts that are overpaid to him.

In the processing of claims where two or more companies or plans are involved, this Fund follows the "Primary-Secondary Rule." The primary plan is the plan which pays first on the claim. If a balance is still due after the primary plan's payment, the claim should be sent to the secondary plan for consideration.

General Rule

In determining which of the plans is primary or secondary, this Trust Fund will apply the rules outlined below. The first rule which applies to the situation will be used.

1. The plan without a coordination of benefits provision is always primary.

2. The plan covering the person as a participant is primary to the plan covering the person as a dependent.

3. The plan covering the person as an active participant is primary to the plan covering the person as a retiree or self-pay participant.

4. The plan covering the person for the longest continuous period is primary to the plan covering the person for a shorter period if the person has the same type of eligibility in both plans.

Dependent Child Rules

In the case of a dependent child where the parents are not divorced, this Plan uses the "birthday rule." This means the plan of the parent whose birthday occurs earlier in the Calendar Year is primary. If the other plan does not have the birthday rule, the other plan's rules will determine who is primary.

In the case of a dependent child where the parents are divorced, the rules are:

1. If the parent with custody has not remarried, the plan of the custodial parent is primary to the plan of the non-custodial parent.

2. If the parent with custody has remarried, the plan of the custodial parent is primary, the plan of the custodial stepparent is secondary and the plan of the non-custodial parent is third.

3. If a Qualified Medical Child Support Order (QMCSO) provides a different order of benefit determination, the QMCSO will be followed. A copy of the QMCSO will be required.

NOTE: These coordination of benefits provisions do not apply to any individual policy you may have purchased on a non-group basis. COBRA Continuation Coverage under this Trust Fund is NOT regarded as an individual policy.

MISCELLANEOUS PROVISIONS

For any dental procedure marked "B/R" (by report), the Fund will determine the allowance based upon the nature and extent of the services performed. A dental procedure of an equivalent gravity and severity listed in the Summary of Benefits shall be used as the basis for the Trust Fund's determination.

Amounts payable for claims will be paid to the member unless the person or claimant has authorized payment directly to the dentist rendering the dental services. See, however, the Benefit Claims and Appeals Procedures on pages 109 to 128 of this Plan Booklet for the effect of assignment of your benefits to a dentist or other provider.

The Trustees may require you to have a Trust Fund-referred dentist review the work performed prior to claims payment.

If any benefit is payable after your death, payment to the provider of services or any person related to you whom the Trust Fund deems is entitled to the payment will discharge the extent of the Fund's obligation.

PAYMENT OF CLAIMS

How to File a Claim

1. Obtain a claim form from the Administrative Office or your Local Union.

2. File one claim form for each claim.

3. Upon completion of the claim form, attach itemized bills and forward to:

Administrative Office
Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

For claim assistance, write the Administrative Office or call (800) 824-4427.

Post-service claims may also be transmitted by electronic means. Many providers submit their own billing forms either in writing or in electronic format. However, it is still your responsibility to ensure the claim is submitted.

All claims must be filed within one year after the date the expense was incurred (see "Benefit Claim and Appeal Procedures" on pages 109 to 128 of this Plan Booklet).

DISCLAIMER: THE SCHEDULED DENTAL PLAN BENEFITS DESCRIBED IN THIS SECTION OF THE BOOKLET ARE NOT INSURED BY ANY CONTRACT OF INSURANCE AND THERE IS NO LIABILITY FOR THE BOARD OF TRUSTEES OR ANY INDIVIDUAL OR ENTITY TO PROVIDE PAYMENT OVER AND BEYOND THE AMOUNTS IN THE FUND COLLECTED AND AVAILABLE FOR SUCH PURPOSE.

CONTRIBUTIONS TO THIS PLAN FOR THE PURPOSE OF PROVIDING BENEFITS TO ELIGIBLE INDIVIDUALS ARE MADE BY THE EMPLOYER ON A MONTH-TO-MONTH BASIS ACCORDING TO A COLLECTIVE BARGAINING AGREEMENT. SHOULD COLLECTIVE BARGAINING AGREEMENTS NOT PROVIDE SUFFICIENT FUNDING TO MAINTAIN THE PRESENT BENEFITS, THE TRUSTEES RESERVE THE RIGHT TO CHANGE THE ELIGIBILITY RULES, REDUCE THE BENEFITS, OR ELIMINATE THE PLAN, IN WHOLE OR IN PART, AS MAY BE REQUIRED BY THE CIRCUMSTANCES.

DeltaCare USA Dental Plan

The following benefits apply only if dental contributions are paid on your behalf and if you have elected to be covered by the DeltaCare USA dental plan.

The DeltaCare USA dental plan is a prepaid HMO plan. This dental plan requires that you select a contract dentist and use that dentist for all of your dental care needs. There is no deductible or calendar year maximum and claim forms are not required when using network providers. Most procedures are provided at no charge to you. Preauthorization is not required except for certain endodontic and periodontic treatments. Orthodontia is covered under this plan. The dental services of the DeltaCare USA plan are provided only when performed or authorized by the DeltaCare USA dental office you have selected.

The following table is a summary of the most frequently utilized benefits and their copayments. Please refer to the DeltaCare USA *Combined Evidence of Coverage and Disclosure Form* booklet to learn more about what is covered under each benefit (including exclusions and limitations) and additional benefits that are not included in this summary. A copy of DeltaCare USA's *Combined Evidence of Coverage and Disclosure Form* booklet is available from the Administrative Office or by calling DeltaCare USA at (800) 422-4234.

SUMMARY OF BENEFITS

BENEFITS	COVERAGE
Annual Maximum	None
Deductible	None
	COPAYMENT
Office Exam	No Charge
Office Visit – after regularly scheduled hours	$ 20.00
Emergency dental coverage for out-of-area emergency services	$100.00
Preventive	
Prophylaxis cleaning – adult – one per six month period	No Charge
Additional prophylaxis cleaning – adult (within the six month period)	$ 45.00
Prophylaxis cleaning – child – one per six month period	No Charge
Additional prophylaxis cleaning – child (within the six month period)	$ 35.00
Diagnostic	
Bitewing – single film Bitewings – two films Bitewings – three films	No Charge
Panoramic film	
Restorative	
Amalgam – one, two or three surface, primary or permanent	No Charge
Inlay – porcelain/ceramic one surface	$135.00
Inlay – porcelain/ceramic two surfaces	$150.00
Inlay – porcelain/ceramic – three or more surfaces	$160.00
Periodontics	
Periodontal scaling and root planing – one to three teeth per quadrant - limited to four quadrants during any 12 consecutive months	No Charge
Periodontal scaling and root planing – four or more teeth per quadrant – limited to four quadrants during any 12 consecutive months	No Charge
Prosthodontics	
Inlay – porcelain/ceramic, two surfaces	$150.00
Inlay – porcelain/ceramic, three or more surfaces	$160.00
Crown – ¾ porcelain/ceramic	$195.00
Prosthodontics (removable)	
Complete Denture	$100.00
Partial Denture – Including any conventional teeth, rests & clasps	$ 80.00
Repair broken complete denture base	$ 15.00
Replace broken teeth – per tooth	$ 5.00
Oral Surgery	
Extraction – coronal remnants – deciduous tooth	No Charge
Extraction – erupted tooth or exposed root (evaluation and/or forceps removal)	No Charge
Removal of impacted tooth – soft tissue	$ 25.00
Removal of impacted tooth – partially bony	$ 50.00

	COPAYMENT
Orthodontia	
Pre-orthodontic treatment visit	$ 25.00
Comprehensive orthodontic treatment of the adolescent dentition – adolescent to age 19	$1,700.00
Comprehensive orthodontic treatment of the adult dentition – adults, including covered dependent adult child	$1,900.00

ANNUAL AND LIFETIME MAXIMUMS AND OTHER BENEFIT LIMITS

There are no out-of-pocket maximums, annual maximum, or lifetime maximums under the DeltaCare USA Dental plan. Please refer to the Description of Benefits and *Combined Evidence of Coverage and Disclosure Form* booklet from DeltaCare USA for more information and specific copayments for each service. Please note that only covered services are listed. All other services are available at the provider's usual fee.

A lifetime maximum of one orthodontic course of treatment per participant during your entire eligibility period with DeltaCare USA Dental plan shall apply.

USE OF NETWORK PROVIDERS AND COMPOSITION OF NETWORK

DeltaCare USA maintains a network of primary dental offices. Except for emergency dental services, you must receive all your dental care from a DeltaCare USA network dentist. When you enroll in the DeltaCare USA plan, you will be able to select a primary dental office for yourself and your dependents. Individual family members may choose different dental offices. If you do not select a dental office at the time of enrollment, DeltaCare USA may assign you to a dental office in a location convenient to your home zip code.

CONDITIONS AND LIMITS ON SELECTION OF PRIMARY CARE PROVIDERS AND SPECIALISTS

You may choose any dental office from those shown on the current DeltaCare USA Dental Office listing which all members receive. Should a chosen office be closed to new enrollment, DeltaCare USA will advise you that an alternative office must be selected.

A request to change dental offices can be done by calling the Customer Service Department at (800) 422-4234, as described in DeltaCare USA's Description of Benefits and *Combined Evidence of Coverage and Disclosure Form* booklet. In order to ensure that your contract dentist is notified, changes in contract dentists must be requested prior to the 21st of the month for changes to be effective on the first day of the month. .

As a private practice, each dental office sees many patients including DeltaCare USA members, and maintains its own internal management and scheduling policies. DeltaCare USA providers are generally available during normal business hours. Your appointment time will depend upon the service the dental office has determined necessary for you, their availability, and yours.

You may find when you call a DeltaCare USA Dental Office that certain more popular appointment times are more difficult to obtain than others. For these reasons, DeltaCare USA urges you to schedule any appointments well in advance and to be as flexible as possible in your choice of times.

Please remember that time is valuable both to you and your dental office. If you cannot keep a scheduled appointment, notify your dental office at least 24 hours in advance, or you may be responsible for a broken appointment fee noted in your DeltaCare USA *Combined Evidence of Coverage and Disclosure Form* booklet.

PROVIDER LISTINGS

The DeltaCare USA *Combined Evidence of Coverage and Disclosure Form* booklet each member receives offers instructions on how to obtain provider directory information. New members also receive a provider directory with their enrollment material.

Obtaining provider information can also be achieved by going to the DeltaCare USA web site at **http://www.deltadentalins.com**. Select the "find a Dentist" icon and then choose the DeltaCare USA network. You can then search for providers by city and print maps to their location from your home.

If you have further questions regarding directories or providers, please call the DeltaCare USA Customer Service Department toll-free at (800) 422-4234. They can answer your questions or mail a directory to your home.

EMERGENCY SERVICES

If emergency services are needed, you should contact your contract dentist whenever possible. If you are a new enrollee and do not have an assigned contract dentist yet, and you need emergency services, you should contact DeltaCare USA's Customer Service Department at (800) 422-4234 for help in locating a contract dentist. Benefits for emergency services by an out-of-network dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1. Have made a reasonable attempt to contact the contract dentist and the contract dentist is unavailable or you cannot be seen within 24 hours of making contact; or

2. Have made a reasonable attempt to contact DeltaCare USA prior to receiving emergency services, or it is reasonable for you to access emergency services without prior contact with DeltaCare USA; or

3. Reasonably believe that your condition makes it dentally/medically inappropriate to travel to the contract dentist to receive emergency services.

Benefits for emergency services not provided by the contract dentist are limited to a maximum of $100.00 per emergency less the applicable copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your contract dentist.

COVERAGE FOR OUT-OF-NETWORK SERVICES

You can receive your covered out-of-network emergency dental care when you are outside of the United States through a partnership between DeltaCare USA and International SOS Assistance, Inc. (I-SOS). I-SOS provides referral to 3,200 dentist or dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help you find a dentist.

For more information, check the web site at **http://www.deltadentalins.com** or call (800) 523-6586 from the U.S. Once you leave the U.S., you can call I-SOS at (215) 942-8226 – collect.

When you see an I-SOS dentist, you must pay for your treatment at the time of service and get a detailed receipt from the dentist. In addition, to providing the dentist's name and address (including country), this receipt should describe the services performed by the dentist and indicate the tooth or teeth that were treated. It should also indicate whether the dentist's charges were billed in U.S. dollars or another currency.

Once DeltaCare USA receives your claim, they will reimburse you subject to the terms and conditions of your DeltaCare USA coverage. Reimbursement is based on the out-of-network emergency benefit provided through your group plan noted above. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

SPECIALIST SERVICES

Specialist and orthodontic services must be referred by the assigned contract dentist and preauthorized in writing by DeltaCare USA. All preauthorized specialist services will be paid by DeltaCare USA less any applicable copayments. If an enrollee is assigned to a dental school clinic for specialist services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

If the services of a contract orthodontist are needed, please refer to orthodontics in the *Description of Benefits and copayments, and limitations and exclusions* to determine which procedures are covered under this program.

SECOND OPINION

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your contract dentist. DeltaCare USA may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and time frames for second opinion authorizations, contact DeltaCare USA's Customer Service Department at (800) 422-4234 or write to DeltaCare USA.

Second opinions will be provided at another contract dentist's facility, unless otherwise authorized by DeltaCare USA. DeltaCare USA will authorize a second opinion by an out-of-network provider if an appropriately qualified contract dentist is not available. DeltaCare USA will only pay for a second opinion which DeltaCare USA has approved or authorized. You will be sent a written notification should DeltaCare USA decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to pages 8 to 9 in the *Combined Evidence of Coverage and Disclosure Form* booklet for information on Enrollee Complaint Procedures.

LIMITATIONS AND EXCLUSIONS

Limitations

1. The reference of certain benefits is limited. All frequency limitations are listed in the *Combined Evidence of Coverage and Disclosure Form* booklet.

2. Benefits provided by a pediatric dentist are limited to children through age seven following an attempt by the assigned contract dentist to treat the child and upon prior authorization by DeltaCare USA, less applicable copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

3. The cost to an enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the contract orthodontist's usual fee for the treatment plan. The contract orthodontist will prorate the amount for the number of months remaining to complete treatment. The enrollee makes payment directly to the contract orthodontist as arranged.

4. Orthodontic treatment in progress is limited to new DeltaCare USA enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan. DeltaCare USA is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

5. If the enrollee accepts a treatment plan from the contract dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the enrollee may be charged an additional $100 above the listed copayment for each of these services after the sixth unit has been provided.

6. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions.

Exclusions

1. Any procedure that is not specifically listed under the Description of Benefits and copayments in the *Combined Evidence of Coverage and Disclosure Form* booklet.

2. Services provided to a member outside of the member's primary care dental office and which is not preauthorized by DeltaCare USA (including specialty care services). (Please see item 5 in the limitations section above for coverage of out-of-network emergency dental services.)

3. Any procedure that in the professional opinion of the contract dentist:

    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

b. is inconsistent with generally accepted standards for dentistry

4. Consultation for non-covered benefits.

5. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

6. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges).

7. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

8. All related fees for admission, use or stays in a Hospital, out-patient surgery center, extended care facility, or other similar care facility.

9. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants and appliances associated therewith) and personalization and characterization of complete and partial dentures.

10. Prescription drugs.

11. Services solely for cosmetic purposes, with the exception of external bleaching, per arch, or for conditions that are a result of a hereditary or developmental defect, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

12. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

13. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

14. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.

15. Lost, stolen or broken orthodontic appliances.

16. Myofunctional and parafunctional appliances and/or therapies.

17. Dental services received from any dental facility other than the assigned contract dentist, a preauthorized dental specialist, or a contract orthodontist except for *emergency services* as described in the contract and/or *Combined Evidence of Coverage and Disclosure Form* booklet.

18. Dental expenses incurred in connection with any dental or orthodontic procedure started before the enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

CLAIMS AND APPEALS PROCEDURES

Claims for Reimbursement

Claims for covered emergency services or preauthorized specialist services should be submitted to DeltaCare USA within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is:

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703

Enrollee Complaint Procedure

DeltaCare USA shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of DeltaCare USA, or the quality of dental services performed by a contract dentist, you may call DeltaCare USA's Customer Service Department at (800) 422-4234, or the complaint may be addressed in writing to:

Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, CA 90703-8579

Written communication must include: 1) the name of the patient, 2) the name, address, telephone number and identification number of the primary enrollee, 3) the name of the client and 4) the dentist's name and facility location.

Complaint/grievance forms and a description of the complaint/grievance procedure are available directly from DeltaCare USA, or DeltaCare USA's web site, and at each contracted provider's facility, and are provided promptly upon request.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with DeltaCare USA within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the

scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, DeltaCare USA shall consult with a dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within five calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, DeltaCare USA will provide the enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed DeltaCare USA's grievance process, or you have been involved in DeltaCare USA's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care (DMHC). You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against DeltaCare USA, you should first telephone DeltaCare USA at (800) 422-4234 and use DeltaCare USA's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by DeltaCare USA, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of dental decisions made by DeltaCare USA related to the dental necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent dental services. The Department also has a toll-free telephone number ((888) HMO-2219) and a TDD line ((877) 688-9891) for the hearing and speech impaired. The Department's internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

IMR has limited application to your dental program. You may request an IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the right under ERISA. You may bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W., Washington, D.C. 20210

PRESCRIPTION DRUG BENEFITS

IMPORTANT
PRESCRIPTION DRUG BENEFITS ARE AVAILABLE FOR ALL PARTICIPANTS

Prescription drug benefits are provided through the OptumRx drug program. Eligible employees and their dependents are enrolled when the eligible employee fills out the Enrollment and Plan Selection Form. Participants can get their acute care prescriptions filled at any participating OptumRx network pharmacy. Maintenance medications are available through the OptumRx mail order program.

Summary of Benefits

TYPE OF PRESCRIPTION	TYPE OF DRUG	COPAYMENT
Walk-in Prescriptions (Retail) 30-day supply with refills • refills not to exceed a 30-day supply • must be filled at a participating pharmacy	 Generic Formulary Brand Non-Formulary Brand	 $10 $20 $40
Mail-Order Prescriptions 90-day supply with refills • refills not to exceed a 90-day supply	 Generic Formulary Brand Non-Formulary Brand	 $10 $30 $50
Note: Preventive Service Prescription Drugs will be covered at $0 copayment for generics (or formulary/non-formulary brand drugs if generic/formulary brand drugs are medically inappropriate) to the extent recommended in the guidelines by the U.S. Preventive Care Task Force, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as applicable (see description for "Preventive Service Prescription Drugs" under "Covered Drugs and Supplies" below).		

Out-Of-Pocket Maximum

Indemnity Medical Plan Participants – There is a combined out-of-pocket maximum for medical benefits provided through the Indemnity Medical Plan and for prescription drug benefits provided through the indemnity prescription drug program of $6,600/person and $13,200/family (may be increased in the future, as permitted under section 1302 (c) (1) of the Patient Protection and Affordable Care Act of 2010). In addition to out-of-pocket medical costs, the combined out-of-pocket maximum includes any cost-sharing (e.g., copayments) for prescription drugs covered under the indemnity prescription drug program. Please see the Indemnity Medical Plan section on page 31 of this Plan Booklet for more information.

Kaiser Participants – There is an out-of-pocket maximum for prescription drug benefits provided through the indemnity prescription drug program for participants enrolled in the Kaiser Plan of $5,100/person and $10,200/family in 2017 (may be adjusted in 2018 and later as permitted under section 1302 (c) (1) of the Patient Protection and Affordable Care Act of 2010). The out-of-pocket

maximum includes any cost-sharing (e.g., copayments) for prescription drugs covered under the indemnity prescription drug program.

Covered Prescriptions

Drugs and medicines are covered if they meet the following criteria:

1. They are prescribed by a Physician;

2. They require a prescription by law, other than for insulin or syringes;

3. They are prescribed to treat an illness, bodily injury, or mental or nervous disorder; and

4. They are not excluded items as described in the "Limitations and Exclusions" section below.

Please also see the "Covered Drugs and Supplies" section on pages 92 to 93.

Generic Drug Substitutions

Generic substitutes will be used to replace brand name prescription drugs when appropriate and permissible by law. If a Physician has indicated that a brand name drug must be dispensed due to medical necessity or that the prescription may not be substituted and must be filled as written, then the brand name drug will not be replaced by a generic substitute and the higher copayment will apply.

Walk-In Program

You may go to any of the OptumRx participating pharmacies to fill a prescription or refill. Be sure to present your prescription drug identification card to the participating pharmacy whenever you have a prescription filled or refilled. You will be required to pay the applicable copayment at the time you purchase the prescription or refill. You can receive a 30-day supply with refills. Refills may not exceed a 30-day supply.

Partial Listing of Current Participating Pharmacies in California (at time Plan Booklet was printed):

Albertson's	Rite Aid
CVS	Target
Pavilions	Vons
Ralphs	Walgreens

No benefits are payable for prescriptions filled by non-participating pharmacies or for prescriptions that are not medically necessary.

Mail-Order Program

OptumRx has a convenient mail-order program that is an inexpensive way for you to order up to a 90-day supply of any covered prescription drug for direct delivery to your home.

Unless your Physician specifies otherwise, your prescription will be filled with a generic equivalent when available and permissible by law.

ADVANTAGES OF USING THE MAIL-ORDER PROGRAM
You can save money and time. Order up to a 90-day supply of medication for less money than it would cost you at a retail pharmacy. Your medications are conveniently delivered to your home via U.S. Mail or UPS. Since you receive up to a 90-day supply, you will be spared the bother of frequent re-orders.

MAINTENANCE MEDICATIONS
All maintenance medications (medication taken on a routine and continuing basis) are available through the mail-order program. In order to insure that you have your medication when you need it, ask your Physician to write you *two* prescriptions: the first should be for a 30-day supply, with up to one refill (to be filled at a participating retail walk-in pharmacy); the second should be for a 90-day supply, with the number of appropriate refills (to be sent to the mail-order program).

HOW TO USE THE MAIL-ORDER PROGRAM

1. When your Physician writes you a prescription, you can have up to a 90-day supply of medication (plus refills, if appropriate) filled by the mail-order program. If you have any questions, call the OptumRx mail service pharmacy customer service at (800) 562-6223.

2. Complete the Patient Profile Questionnaire (initial order form) with your first order only. Be sure to answer all the questions for yourself and your Dependent. The Patient Profile Questionnaire may be requested from the Administrative Office at (562) 463-5080 or (800) 824-4427 or OptumRx at (800) 562-6223.

3. Send the completed Patient Profile Questionnaire and your original (not a photocopy) written prescription to OptumRx using the pre-addressed order form. Enclose a check or money order, or your VISA, Discover, or MasterCard number for the required copayment for each prescription.

   The address for new prescriptions is:

   OptumRx
   P.O. Box 509075
   San Diego, CA 92150-9075

4. Your order will be mailed to you via UPS or First Class U.S. Mail. Please allow 14 days for delivery from the day you place your order. Reordering and refill information for your next order will be included with your prescription.

If you have customer service questions, contact OptumRx at (800) 562-6223.

Specialty Drugs (Injectables and Non-Injectables)

OptumRx provides coverage for Specialty Drugs (injectables and non-injectables) through the mail-order program. (Epinephrine injection and kits and insulin are available at retail pharmacies.) Your Physician must call OptumRx at (800) 562-6223 to obtain prior authorization before you place your order. You may receive a 30-day supply through the mail. A $30 copayment applies.

Certain Specialty Drug (injectable and non-injectable) medications are covered at contracted OptumRx pharmacies for emergency after-hours coverage. If you require an emergency supply of your medication, you can obtain a 14-day supply at participating pharmacies ($30 copayment applies).

For further information, call OptumRx customer service at (800) 562-6223.

Compound Medication Management Program

Compounding is a practice by which a licensed pharmacist or physician combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. This may be done if the health needs of a patient cannot be met by an FDA-approved medication (due to allergies to certain standard drug ingredients or inability to utilize drugs in a particular form), or to add vitamins/supplements for cosmetic or other alternative purposes. However, compound drugs are not FDA-approved and this may lead to potential misuse. Ingredients used in compound drugs are not tested for efficacy or purity. Due to concerns about participant safety and drug efficacy, the following Compound Medication Management Program applies:

- Non-FDA approved bulk chemicals will be excluded from coverage as compound drug ingredients (contact OptumRx for the most recent list of such chemicals; this list is subject to change);

- Bulk chemicals for vitamins/supplements typically available over-the-counter will be excluded from benefit coverage as compound drug ingredients;

- Products for cosmetic uses will be excluded from coverage as compound drug ingredients; and

- Ingredients used in compounding topical formulations when the medication is not approved by the FDA for this route of administration will be excluded from coverage.

If you are prescribed a compound ingredient that fits any of the criteria above, coverage of the compound medication will not be approved. You can still purchase the medication, but you will pay the full cost of the prescription. If you have a deductible or out-of-pocket maximum, non-covered charges will not count toward either. As you and your doctor make decisions about your prescription medications, we encourage you to discuss other covered options that may also treat your condition.

In addition, any compound drug that costs $50 or more will require prior authorization by OptumRx. You will be notified of this when you go fill your prescription at the pharmacy. The pharmacist will initiate the prior authorization procedure by contacting OptumRx to request a prior authorization. OptumRx will either approve the drug or provide you with documentation as to why it was not approved. If you have any additional questions, please contact OptumRx at (800) 797-9791. If you are submitting a prescription drug through the OptumRx mail order program, please contact OptumRx by calling (800) 711-4555 or online at **www.optumrx.com**.

Covered Drugs and Supplies

1. Federal Legend Drugs.
2. State Restricted Drugs.
3. Compound drugs with at least one federal legend or state restricted ingredient (but see the Compound Medication Management Program for certain exclusions).
4. Diabetic Supplies:
    a. Blood and urine glucose test strips
    b. Insulin cartridges
    c. Insulin pre-filled pen with insulin & needle (disposable)
    d. Insulin syringes & needles
    e. Lancets
    f. Pen needles
5. Oral Contraceptive Coverage/Birth Control:
    a. Formulary oral contraceptives
    b. Transdermal patches (e.g., Ortho Evra)
    c. Morning after pills
    d. Diaphragms
    e. Cervical caps
    f. Birth control ring (e.g., NuvaRing)
6. Retin-A, Azelex, Differin, Avita (up to age 26).

7. Glucagon

8. Formulary cough medication with codeine (Schedule V medications).

9. Epinephrine injectables and kits (bee sting kits).

10. Formulary CII amphetamines and stimulants to treat ADD and ADHD.

11. Formulary progesterone products (e.g., Prometrium, Crinon, Progesterone Powder).

12. Inhaler extender devices.

13. Medically necessary prescription vitamins (e.g., Calcitriol, Folic Acid, Vitamin A).

14. Saline for inhalation.

15. Narrow Therapeutic Index Drugs, Dilantin and Lanoxin are covered as a single-source brand drug and will require a brand name drug copayment. Generic Dilantin and Lanoxin will be charged the generic copayment.

16. Preventive Service Prescription Drugs and Supplies (including certain over-the-counter products, e.g., aspirin, prescribed by a health care provider) will be covered to the extent recommended as follows:

    a. Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved;

    b. Immunizations for routine use in children, adolescents, and adults (i.e., those immunizations that have been adopted for recommendation by the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention);

    c. Preventive care and screening for infants, children and adolescents, as provided for in the comprehensive guidelines by the Health Resources and Services Administration ("HRSA"); and

    d. Preventive care and screening for women, as provided for by the HRSA that are not otherwise addressed by Task Force recommendations.

Limitations and Exclusions

The Prescription Drug Benefit Plan does not provide benefits for (except as otherwise covered above):

1. Drugs or medicines purchased and received prior to the member's effective date or subsequent to the member's termination.

2. Medications received/consumed while in a licensed Hospital or facility.

3. Drugs dispensed for use in a Hospital or rest home.

4. Drugs dispensed in a Physician's office for which you are not required to pay.

5. Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopeial Convention, or in the American Hospital Formulary Services edition of Drug Information; medications limited to experimental or investigational use by law.

6. Over-the-counter or patent medicines that do not require a written prescription.

7. Any prescription drugs provided for illness or injury covered by any workers' compensation or occupational disease law.

8. Any prescription drugs provided for an illness or injury which was a result of participation in or consequence of the commission of a felony or misdemeanor.

9. Any prescription drug provided by or paid for by the United States government or any instrumentality thereof.

10. Any prescription drugs, medications, supplies, or services for which members are not required to pay, which are furnished by or payable under any plan or law of any government or furnished by a county, parish, municipal Hospital, or Physician's office where there is no legal requirement to pay for such supplies or services.

11. Any prescription drugs, medications, supplies, or service for injury or illness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain.

12. Appliances or prosthetics.

13. Any non-drug item (i.e., hearing aids, eye refractions, glasses, or contact lenses).

14. Dental-related products (Atridox, Periostat, Peridex).

15. Any medicines, drugs, or supplies due to illness which is covered by a Workers' Compensation Act or other similar legislation.

16. Any drugs not medically necessary to treat an illness or injury.

17. Health foods, dietary supplements, nutritional supplements.

18. Fertility drugs (Clomid).

19. Norplant, Depo-Provera, morning after kits, and over-the-counter contraceptives/birth control items.

20. Insulin pen devices (Novopen, Humulin Pen) and blood glucose monitors.

21. Appetite suppressants (Anorexiants/Anti-obesity drugs).

22. Medications or devices for the treatment of sexual dysfunction including erectile dysfunction, impotence, and anorgasmy or hyporgasmy (including Viagra, Muse, Caverjet).

23. Yohimbine.

24. All smoking cessation products.

25. Oral vaccines.

26. Cosmetic agents (Rogaine, Propecia).

27. Pigmenting and depigmenting agents (Renova, Vaniqa).

28. Penlac.

29. Diagnostic tests (with exception of diabetic testing).

30. Non-medically necessary vitamins and dietary supplements (including vitamins with fluoride).

31. Prescription prenatal vitamins (including Bright Begin Prenatal Bar, Duet DHA, and Embrex).

32. Prescription minerals and supplements (including Thiamine, Iron, Anemagen, Anemagen OB, and Anemagen FE).

33. Unit dose medications (unless only available as unit dose).

34. Homeopathic medications.

35. Irrigation solutions and saline for irrigation.

36. Non-insulin syringes and needles.

37. Services related to a third-party claim are not covered.

38. Compound medications as excluded above under the Compound Medication Management Program.

Notice to Those Eligible for Medicare Part D

Effective January 1, 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available in this Plan to all Medicare eligible employees and/or their dependents, and Medicare eligible dependents of early retirees who are age 65 or older or are disabled and are receiving social security disability benefits, and those with end stage renal disease. The first enrollment period for Medicare Part D coverage is November 15, 2005 through May 15, 2006; each subsequent year it is November 15 through December 31.

A notice containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Trust Fund prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer creditable, and upon your request. "Prior to" means within 12 months before the event in question.

The Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage. Therefore, there is no requirement that you enroll in Medicare Part D. The Plan will notify you if this changes.

DISCLAIMER: THE PRESCRIPTION DRUG BENEFITS DESCRIBED IN THIS MATERIAL ARE NOT INSURED BY ANY CONTRACT OF INSURANCE AND THERE IS NO LIABILITY FOR THE BOARD OF TRUSTEES OR ANY INDIVIDUAL OR ENTITY TO PROVIDE PAYMENT OVER AND BEYOND THE AMOUNTS IN THE FUND COLLECTED AND AVAILABLE FOR SUCH PURPOSE.

CONTRIBUTIONS TO THIS PLAN FOR THE PURPOSE OF PROVIDING BENEFITS TO ELIGIBLE INDIVIDUALS ARE MADE BY THE EMPLOYER ON A MONTH-TO-MONTH BASIS ACCORDING TO A COLLECTIVE BARGAINING AGREEMENT. SHOULD COLLECTIVE BARGAINING AGREEMENTS NOT PROVIDE SUFFICIENT FUNDING TO MAINTAIN THE PRESENT BENEFITS, THE TRUSTEES RESERVE THE RIGHT TO CHANGE THE ELIGIBILITY RULES, REDUCE THE BENEFITS, OR ELIMINATE THE PLAN, IN WHOLE OR IN PART, AS MAY BE REQUIRED BY THE CIRCUMSTANCES.

TIME LIMITATION FOR SECTION 502(a) LAWSUIT

A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision. Please see the section of the booklet entitled "Indemnity Prescription Drug Benefit Claims and Appeals Procedures" for the detailed Indemnity Prescription Drug Benefit Claim and Appeal Procedures (pages 117 to 128 as amendment by Amendments Nos. 12 and 20).

VISION BENEFITS

IMPORTANT
Since benefits are determined by the Collective Bargaining Agreement, please contact the Administrative Office to see if you qualify for this benefit plan.

Vision care benefits are provided directly by the Trust Fund under a self-insured vision plan. Eligible employees and their dependents are enrolled when the eligible employee fills out the Enrollment and Plan Selection Form. Services may be obtained from the provider of your choice. (If you are enrolled in Kaiser, eye exams are available for a $20.00 copayment when authorized by Kaiser.)

If you are eligible for vision benefits under the Managed Care Plan, expenses incurred will be reimbursed in accordance with the Schedule of Benefits shown below. The eye refraction must be performed, and the materials prescribed, by a person licensed to practice as a doctor of medicine, osteopathy or optometry.

Summary of Benefits

BENEFIT	PLAN PAYS
Eye Exam (once per calendar year) *	$ 40.00
Frames (once per calendar year) *	$ 40.00
Lenses (once per calendar year) * Single Vision Bi-Focal Tri-Focal Lenticular	 $ 40.00 $ 50.00 $ 70.00 $120.00
Contact Lenses	$125.00
* Please note that expenses paid by you for covered pediatric (ages 0 through 18) vision services through the Vision Benefits Plan will count towards the per-person or per-family Out-of-Pocket Maximum under the Indemnity Medical Plan, as applicable (if you are enrolled in both the Indemnity Medical Plan and the Vision Benefits Plan).	

Calendar Year Maximums

Vision benefits for an eye exam, frames and lenses are limited to once per calendar year (except with respect to pediatric [ages 0 through 18] vision services, as noted above). Benefits for contact lenses can be for multiple sets of lenses over the course of a calendar year, up to the maximum benefit amount. A “calendar year” is the period of twelve months beginning on January 1 of each year.

Proof of Claim

You must give written proof of claim within 90 days after the services have been rendered, if reasonably possible, but not later than one year after the end of the 90-day period, except in the absence of legal capacity.

A charge is deemed to be incurred on the date on which the service or supply is rendered or obtained.

Limitations and Exclusions

No payment will be made for any expenses incurred in connection with:

1. Payment made under the Trust Fund other than this Vision Benefit.

2. More than one pair of glasses during any calendar year or contact lenses that exceed the maximum benefit amount in any calendar year.

3. Any supplies or services for which you are not required to pay, which are furnished by a County or Municipal Hospital where there is no legal requirement to pay for such supplies or services.

4. Any supplies or services for which you are not required to pay.

5. Any supplies or services covered by a workers' compensation or occupational disease law.

6. Any supplies or services arising from an injury or illness sustained in the course of any occupation or employment for compensation, profit, or gain.

Coordination of Benefits

The vision benefits payable for covered charges incurred will be coordinated with any other group insurance you or your dependents may have.

Coordination means that benefits are paid so that no more than 100% of Reasonable and Customary expenses will be covered under the combined benefits from all the following plans: (1) this Plan, (2) any other group, blanket or franchise insurance coverage, (3) group practice and other group prepayment coverage, (4) group service plans, (5) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, (6) any coverage provided by governmental programs, and (7) any coverage required or provided by statute.

The Fund may obtain or release any information necessary to carry out these provisions, subject to the HIPAA Privacy Rule and Regulations. You must declare your coverage under other plans. The Fund can recover from the member amounts that are overpaid to him.

In the processing of claims where two or more companies or plans are involved, this Fund follows the "Primary-Secondary Rule." The primary plan is the plan which pays first on the claim. If a balance is still due after the primary plan's payment, the claim should be sent to the secondary plan for consideration.

GENERAL RULE
In determining which of the plans is primary or secondary, this Trust Fund will apply the rules outlined below. The first rule which applies to the situation will be used.

1. The plan without a coordination of benefits provision is always primary.

2. The plan covering the person as a participant is primary to the plan covering the person as a dependent.

3. The plan covering the person as an active participant is primary to the plan covering the person as a retiree or self-pay participant.

4. The plan covering the person for the longest continuous period is primary to the plan covering the person for a shorter period if the person has the same type of eligibility in both plans.

DEPENDENT CHILD RULES
In the case of a dependent child where the parents are not divorced, this Trust Fund uses the "birthday rule." This means the plan of the parent whose birthday occurs earlier in the Calendar Year is primary. If the other plan does not have the birthday rule, the other plan's rules will determine who is primary.

In the case of a dependent child where the parents are divorced, the rules are:

1. If the parent with custody has not remarried, the plan of the custodial parent is primary to the plan of the non-custodial parent.

2. If the parent with custody has remarried, the plan of the custodial parent is primary, the plan of the custodial stepparent is secondary and the plan of the non-custodial parent is third.

3. If a Qualified Medical Child Support Order (QMSCO) provides a different order of benefit determination, the QMSCO will be followed. A copy of the QMSCO order will be required.

Payment of Claims

HOW TO FILE A CLAIM
1. Obtain a claim form from the Administrative Office or your Local Union.

2. File one claim form for each claim.

3. Upon completion of the claim form, attach itemized bills and forward to:

Administrative Office
Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1706

For claim assistance, write the Administrative Office or call (800) 824-4427.

Post-service claims may also be transmitted by electronic means. Many providers submit their own billing forms either in writing or in electronic format. However, it is still your responsibility to ensure the claim is submitted.

All claims must be filed within one year after the date the expense was incurred (see "Benefit Claim and Appeal Procedures" on pages 109 to 128 of this Plan Booklet).

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LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

These benefits are insured through The Union Labor Life Insurance Company

IMPORTANT
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS ARE NOT AVAILABLE FOR ALL PARTICIPANTS
Since benefits are determined by the Collective Bargaining Agreement, please contact the Administrative Office to see if you qualify for these benefits.

Life insurance and AD&D insurance is provided to active employees and eligible dependents through The Union Labor Life Insurance Company (hereby called "The Company").

Eligible Class

You are in a class eligible for insurance ("eligible class") if you are an active employee or dependent and meet the eligibility requirements described on pages 1 to 5 of this Plan Booklet.

Summary of Benefits

Life Insurance	**BENEFIT**
Active Employees	$10,000
Dependent Spouse	$ 2,000
Dependent Child Age 6 months to 26 years Birth until 6 months	 $1,000 $ 100
Accidental Death & Dismemberment Insurance	**BENEFIT**
Active Employees Only	$10,000

Active Employee Life Insurance Benefit

If you should die while you are eligible for this life insurance benefit, the amount of insurance shown in the Summary of Benefits will be paid to your named beneficiary. In the event of your death, written notice must be given to the Administrative Office of the Trust Fund or to The Union Labor Life Insurance Company within 12 months thereafter for the benefit to be payable.

EXTENSION OF LIFE INSURANCE DURING TOTAL DISABILITY (WAIVER OF PREMIUM)
A person under the age of 60:

1. who becomes totally disabled while insured under this Policy; and

2. for whom premium payments continue to be made or whose coverage is terminated for failure to meet the eligibility requirements stated in this policy because of total disability;

may apply to continue his or her life insurance under this waiver of premium provision. The initial continuation under this provision will be for 12 months from the date premium payments on behalf of the person cease, but in no event longer than 24 months from the date total disability began.

Waiver of Premium will continue until the earlier of:

1. the date the person's total disability ends; or

2. the end of the 12-month period.

If the total disability extends to the person's attainment of age 65, then continuation of insurance under this provision will continue and all further premiums will be waived.

Additionally, if a person's total disability begins after attainment of age 60, and such person becomes totally disabled while insured under the policy, he or she may apply to continue his or her life insurance under this waiver of premium provision until the date his or her total disability ends, up to age 65.

"Totally disabled" and "total disability" mean:

1. that during the first 24 months of total disability, the person is unable to perform with reasonable continuity the substantial and material duties of his or her business, occupation, or employment due to injury or illness; or

2. after the first 24 months of total disability, the person, due to injury or illness, is unable to engage with reasonable continuity in any other business, occupation, or employment in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, station in life, or physical and mental capacity.

The person must submit satisfactory written proof (the "initial proof") of total disability to the Administrative Office within 12 months from the date the premium payments on behalf of such person cease; but in no event more than 24 months from the date total disability began.

The initial proof must show that the total disability began while the person was insured under the policy. "Initial proof" means completion and submission of the application required for requesting waiver of premium benefits. The date a person's total disability began is shown on the application.

NOTICE OF APPLICATIONS FOR WAIVER DETERMINATION

The Company will give written notice to the applicant within 10 days of receipt of an application for waiver. The notice will state whether the application is approved; and give the reasons for any disapproval. If the application for waiver is disapproved, the person may continue eligibility under this policy for life insurance only if the policyholder continues the person on a premium-paying basis.

A person who is denied continuation of his or her group life insurance through waiver of premium and:

1. is not continued by the policyholder on a premium-paying basis; or

2. did not exercise his or her right to convert to an individual policy of life insurance;

may be entitled to the same conversion rights that applied to the person on the date his or her life insurance would have terminated in the absence of this waiver of premium provision.

A person who holds an individual conversion policy and who has been denied continuation of his or her group life insurance through waiver of premium, may continue his or her coverage under the individual conversion policy.

DEATH OF PERSON BEFORE OR WHILE WAIVER OF PREMIUM IS IN EFFECT
If a person applies for waiver under this provision and dies before his waiver of premium is in effect, the beneficiary must submit written proof that total disability continued without interruption from the date the person became totally disabled to the date of death. Except that if at the time of death, life insurance on the person has been continued on a premium paying basis, the amount of insurance in force under this policy will be paid to the beneficiary, subject to all of the terms and conditions of this policy.

If a person dies while this waiver of premium is in effect, the beneficiary must submit written proof that total disability continued without interruption from the last anniversary of the company's receipt of proof total disability to the date of death.

BENEFIT AMOUNT
The amount of life insurance continued under this waiver of premium, will be the amount of insurance in force for the person on the date premium payments for the person cease; or he or she became totally disabled. The amount of life insurance continued under this waiver of premium is subject to any reduction or termination in the amount of insurance, as shown on the Schedule of Benefits.

Any person who:

1. is approved for waiver under this provision; and

2. hold an individual policy of life insurance through exercise of the conversion privilege under this policy;

is not entitled to receive benefits under both this policy and the individual conversion policy for the same amounts of insurance. At the time of the person's death, payment will be made under this policy only if the individual policy is surrendered to the company without claim other than for return of the premiums paid, less dividends.

CONTINUANCE OF WAIVER OF PREMIUM
A person who has applied for and received approval of waiver of premium for the life insurance benefit under this policy, may continue the waiver of premium for additional 12-month periods, provided the person:

1. remains totally disabled; and

2. provides written proof of continuing total disability no less than 90 days after the termination of the period for which the Company is liable. Failure to furnish proof as required will not invalidate or reduce the benefit if it was not reasonably possible to give proof within the time required provided proof is furnished as soon as reasonably possible and except in the absence of legal capacity, not later than one year from the time proof is otherwise required.

PHYSICAL EXAMINATIONS
The Company, at its own expense, may require a person whose life insurance has been continued by this waiver of premium to be examined by a doctor of its choice, at any reasonable time during the person's first two full years of total disability. After two years, The Company will not require such examination more than once a year.

CONVERSION PRIVILEGE
A person, whose life insurance was continued by this waiver of premium, may be entitled to the same conversion rights that applied to the person on the date his or her life insurance would have terminated in the absence of this waiver of premium provision.

LIFE CONVERSION PRIVILEGE
If your life insurance coverage ends because your employment terminates or your membership in an eligible class terminates, you are entitled to have issued to you by The Union Labor Life Insurance Company, without proof of good health, an individual policy of life insurance up to the amount of insurance which terminated. Disability or other supplementary insurance is not included.

In order to convert your life insurance to an individual policy, you must make written application and pay the first premium within the conversion period. You may convert to any individual policy that is then being offered by The Union Labor Life Insurance Company, other than term insurance or insurance which provides disability or other supplementary benefits. The premium for the policy will be The Union Labor Life Insurance Company's then-customary rate applicable (1) to the form and amount of the policy, (2) to your class of risk, and (3) to your age on the effective date of the individual policy.

Contact the Administrative Office or The Union Labor Life Insurance Company for rules governing your right to convert if your eligible class is terminated.

CONVERSION PERIOD
The 31-day period immediately following the termination of your employment or of the life insurance coverage for your eligible class.

DEATH BENEFIT DURING CONVERSION PERIOD
If you die during the 31-day period specified in the Life Conversion Privilege section, the amount of life insurance you are entitled to convert will be paid under this life insurance benefit.

NOTICE OF CONVERSION PRIVILEGE
If you have not received notice of your right to convert 15 days before the end of the conversion period, you will have an additional 25 days from the date you are notified in which to convert. The life insurance benefit will not be extended beyond the 31st day after the date your employment terminates or the life insurance coverage terminates for your eligible class, and your right to convert will not be extended more than 60 days beyond your initial 31-day conversion period.

Dependent Life Insurance Benefit

If your eligible dependent should die while eligible for this life insurance benefit, the amount of dependent life insurance benefit shown in the Schedule of Benefits will be paid to you if you are living; otherwise, it will be paid to the estate of your deceased dependent.

DEPENDENT'S LIFE CONVERSION PRIVILEGE
If your dependent's life insurance terminates because your employment terminates, you are no longer a member of an eligible class, or you die, then he or she shall be entitled to have issued by The Union Labor Life Insurance Company without proof of good health, an individual policy of life insurance, without disability or other supplementary benefits, in an amount not to exceed the amount of life insurance which terminated.

The rules governing the application, late notification, premium, and types of policies available under your conversion privilege apply also to your dependent's life insurance conversion privilege.

If your dependent dies during the 31-day conversion period, The Union Labor Life Insurance Company will pay the dependent life insurance benefit under this life insurance coverage.

Accidental Death & Dismemberment Benefit (Active Employees Only)

If you have an accident while covered under this accidental death and dismemberment coverage, and it results in any of the losses shown below, directly and independently of all other causes and within 90 days after the date of the accident, the following benefits will be paid as shown in the Schedule of Losses and Benefits below.

The benefits for loss of life shall be paid to your beneficiary. All other benefits shall be paid to you.

SCHEDULE OF LOSSES AND BENEFITS

Full Benefit	$10,000
Benefit for the Loss of:	
Both Hands	$10,000
Both Feet	$10,000
Sight of Both Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and Sight of One Eye	$10,000
One Foot and Sight of One Eye	$10,000
One Hand or One Foot	$ 5,000
Sight of One Eye	$ 5,000

Loss of a hand or foot means the complete and permanent severance of the hand or foot, at, or above the wrist or the ankle joint, respectively. Loss of an eye means the entire and permanent loss of the sight of the eye.

No more than the full benefit will be paid for all losses from one accident.

Limitations and Exclusions

No benefits will be paid for any loss caused or substantially contributed to by any of the following:

1. any attempt at suicide or intentionally self-inflicted injury, while sane or insane;

2. war or any act of war;

3. active participation in a riot, insurrection, or terror activity;

4. committing or attempting to commit a felony;

5. the person’s voluntary intake of any drug unless prescribed by a physician and taken in accordance with the physician’s instructions or any poison, gas, or fumes unless they are the direct result of an occupational accident;

6. being intoxicated as defined by the jurisdiction where the loss occurred;

7. being engaged in an illegal occupation; or

8. engaging in aviation other than as a fare-paying passenger.

Additional Information for Life and AD&D Benefits

BENEFICIARY
You may designate one or more beneficiaries to receive the benefits payable for the loss of your life. You may change your beneficiary designation at any time by written request. The consent of your beneficiary is not required to designate or change your beneficiary.

Your beneficiary designation or change is effective on the date you sign the request, but The Union Labor Life Insurance Company shall not be held liable for making payments to any other person before it is received at the Administrative Office or at The Union Labor Life Insurance Company's Home Office.

If you designate more than one beneficiary, any benefits will be paid equally to the beneficiaries who survive you, unless you specify otherwise.

If no named beneficiary survives you, benefits will be paid to the living person(s) who is the first in the following order of preference: your surviving spouse, your children (in equal shares), your parents (in equal shares), your brothers and sisters (in equal shares), or your estate.

PROOF OF LOSS
Written proof of loss must be furnished to the Administrative Office or The Union Labor Life Insurance Company within 12 months of death for life insurance claims. Proof of loss must be given within 90 days after the loss occurs for accident claims, if reasonably possible, but not later than one year after the date of the loss, except in the absence of legal capacity.

BENEFIT PAYMENT
Amounts payable for accidental death will be paid in accordance with the beneficiary provisions. Any other amounts unpaid at the time of your death may, at the option of The Union Labor Life Insurance Company, be paid either to your beneficiary or your estate, except as provided in the following paragraph. All other amounts will be payable to you.

If any benefits are payable at the death of the insured, or are payable to a participant or beneficiary who is a minor or is incompetent or incapable of executing a valid release and for whom no guardian has been appointed, The Union Labor Life Insurance Company may pay up to $1,000 of any such benefit to any relative by blood or connection by marriage to the insured person determined by The Union Labor Life Insurance Company to be equitably entitled thereto. Such payment shall fully discharge any obligation of The Union Labor Life Insurance Company under the policy to the extent of such payment paid in good faith.

EXAMINATIONS AND AUTOPSIES
Union Labor Life, at its own expense, may require the person for whom claim is made to be examined by a doctor of its choice. In the case of death, The Union Labor Life Insurance Company may have an autopsy performed, where not forbidden by law.

LEGAL ACTION
No action at law or in equity shall be brought to recover the benefits hereunder before 60 days or later than three years after written proof of loss has been submitted as required by policy.

Miscellaneous Provisions

ERROR
If any information regarding an insured is reported incorrectly to The Union Labor Life Insurance Company, and the error affects the coverage, the true facts will determine to what extent, if any, the insured was, or is, covered under the policy.

ASSIGNMENT
No assignment of the policy, or any rights or benefits under the policy, shall be valid unless The Union Labor Life Insurance Company has consented to it in writing.

Payment of Claims

HOW TO FILE A CLAIM

1. Obtain a claim form from the Administrative Office or The Union Labor Life Insurance Company.

2. File one claim form for each claim.

3. Send the completed claim form to:

   Administrative Office
   Southern California Lumber Industry Welfare Fund
   1200 Wilshire Boulevard, Fifth Floor
   Los Angeles, CA 90017-1906

   You may also send your claim form directly to The Union Labor Life Insurance Company at:

   The Union Labor Life Insurance Company.
   180 Montgomery Street, Suite 1100
   San Francisco, CA 94104

4. For claim assistance, write or call the Administrative Office. You may also call the The Union Labor Life Insurance Company Group Life Claims Department at (866) 795-0680.

5. All claims must be filed within one year after the date of death or injury. (see "Benefit Claim and Appeal Procedures" on pages 109 to 128 of this Plan Booklet).

DISCLAIMER: CONTRIBUTIONS TO THE LIFE INSURANCE PLAN FOR THE PURPOSE OF PROVIDING BENEFITS TO ELIGIBLE INDIVIDUALS ARE MADE BY THE EMPLOYER ON A MONTH-TO-MONTH BASIS ACCORDING TO A COLLECTIVE BARGAINING AGREEMENT. SHOULD COLLECTIVE BARGAINING AGREEMENTS NOT PROVIDE SUFFICIENT FUNDING TO MAINTAIN THE PRESENT BENEFITS, THE TRUSTEES RESERVE THE RIGHT TO CHANGE THE ELIGIBILITY RULES, REDUCE THE BENEFITS, OR ELIMINATE THE PROGRAM, IN WHOLE OR IN PART, AS MAY BE REQUIRED BY THE CIRCUMSTANCES.

BENEFIT CLAIM AND APPEAL PROCEDURES

The Indemnity Medical Plan benefits provided to you and your eligible dependents which are fully described in this Plan Booklet will only be available if you comply with the procedures set forth below.

Administrative Review

PRE-SERVICE CLAIMS

A pre-service claim for medical care is a claim that the Plan requires approval of in advance of obtaining the medical care. This Plan does not condition the receipt of medical care on the approval in advance of obtaining the medical care. As such, there are generally no pre-service claims (urgent or non-urgent). Although medical care is not conditioned upon pre-approval, the Plan will not pay for charges incurred for services or supplies that are not medically necessary. In this regard, members are encouraged, but not required, to obtain Hospital pre-admission certification through Blue Cross prior to any admission (see pages 38 to 39). Notwithstanding, if you voluntarily seek pre-admission authorization, and Blue Cross determines that the services or supplies are not medically necessary, you may request an internal appeal and/or a standard/expedited external review of the determination through Blue Cross, as applicable.

Please send your request in writing to Blue Cross, at P.O. Box 60007, Los Angeles, CA 90060-0007 or if you are in need of an urgent care appeal or a standard/expedited external review call Blue Cross at 1-800-274-7767.

CONCURRENT CARE CLAIMS

A concurrent care claim is a claim for continued treatment that has been provided over a period of time or number of treatments which was previously approved through the voluntary pre-admission authorization process, or for a decision made regarding a request(s) by you to extend a course of treatment beyond what was approved. The Plan will not reduce or terminate treatment previously approved as medically necessary under the voluntary process. This Plan also does not condition the receipt of continuing medical care on the approval in advance of obtaining the continuing medical care, and, as such, there are generally no concurrent claims (urgent and non-urgent).

Although continuing medical care is not conditioned upon pre-approval, the Plan will not pay for charges incurred for services and supplies that are not medically necessary. In this regard, members are encouraged, but not required, to obtain a continuing care authorization through Blue Cross. Notwithstanding, if you voluntarily seek a concurrent care authorization, and Blue Cross determines that the continuing services or supplies are not medically necessary, you may request an internal appeal and/or a standard/expedited external review of the determination through Blue Cross, as applicable. Please see procedures under “Pre-Service Claims” above for instructions on contacting Blue Cross.

PRE-SERVICE OR CONCURRENT CARE CLAIMS OR CLAIMS FOR BENEFIT COVERAGE DETERMINATIONS

The Indemnity Medical Plan also does not require pre-approval of pre-service or concurrent claims or claims for benefit coverage before medical care is received for either urgent or non-urgent claims. Therefore, the Department of Labor ("DOL") benefit claims procedure regulations, including any time-frame restrictions within which to make benefit coverage determinations, do not apply. However, this does not mean the Plan will pay for the medical expenses incurred when the billing is actually received. There are cost-sharing arrangements and other limitations and exclusions under the Plan that must be taken into consideration.

Notwithstanding, for convenience purposes only, if you and/or your medical provider have any questions regarding a pre-service or concurrent care claim as benefit coverage issues, you may request, in writing, a decision by Blue Cross or a determination by the Plan, as applicable, determination by sending your request to Blue Cross at 21555 Oxnard Street, Woodland Hills, CA 91367 or to the Southern California Lumber Industry Welfare Fund, 1200 Wilshire Boulevard, Fifth Floor, Los Angeles, CA 90017-1906. Blue Cross or the Administrative Office, as applicable, will respond within a reasonable time period. However, no such request will be viewed as a "claim for benefits" as defined in the DOL Benefit Claims and Appeal Procedures regulations. Please note the Plan cannot tell you or the medical provider the specific amount payable under the Plan until it receives the appropriate medical claim form and reviews the actual request for payment.

POST-SERVICE CLAIMS

A post-service claim is a claim for benefits under the Plan that is not a pre-service claim (i.e., treatment has been rendered or a service performed and you are requesting payment under the Plan). Post-service claims includes requests for actual payment by the Plan at any pre-service claim or concurrent care claim. All claims under these Procedures are post-service claims.

Benefit Claim Procedures for Post-Service Claims

A post-service claim must be submitted in writing to the Administrative Office in accordance with the following procedures before any benefits can be paid:

If you or your eligible dependent received medical treatment, you must:

1. Obtain a claim form from the Administrative Office or your Local Union.

2. Complete the claim form for each claim.

3. Submit the form to your medical provider for completion of its portion of the form (or for attachment of an itemized billing).

4. Attach itemized bills to the form and forward to:

Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

For post-service claims assistance, write the Administrative Office or call (526) 463-5080 or (800) 824-4427. Claims must be filed within 90 days of service if reasonably possible, but not later than one year after the 90-day period, except in the absence of legal capacity. Post-service medical claims may also be transmitted by electronic means. Many providers submit their own billing forms either in writing or in electronic format. However, it is still your responsibility to ensure the claim is submitted.

Most Hospitals and Physician's offices submit their own standard billing forms either in writing or in electronic format. However, it is still your responsibility to ensure either the Hospital or Physician or the Fund's claim form is submitted.

The Administrative Office will notify you of its decision within 30 days of receipt of the claim. The Plan is allowed one 15-day maximum extension if the claim decision cannot be made for reasons beyond the control of the Plan and the Administrative Office notifies you prior to the expiration of the initial 30-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and the Administrative Office may also agree to further extensions of these time periods.

INCOMPLETE CLAIMS

If you fail to follow the above-referenced procedures or do not provide sufficient information to decide a claim, the Administrative Office will notify you within 30 days of the failure and inform you what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide the specified information. You and the Administrative Office may agree to further extensions of this time period. The time period for deciding a claim shall be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

NOTICE OF CLAIMS DENIAL/NOTICE OF ADVERSE BENEFIT DETERMINATION

If any claim is denied in whole or in part on the basis of eligibility; that the benefits will not be paid under the Plan because they are not medically necessary or not covered; or if your coverage is rescinded; you will be provided with a notice of denial which will contain:

1. Date of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a reference to the specific Plan provision(s) on which the denial is based;

5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits;

6. A description of the Plan's standard used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request;

7. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

8. An explanation of the Internal Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Internal Appeal Procedures (see below);

9. A statement that the diagnosis and treatment codes, and their corresponding meanings, will be provided free of charge to you upon request;

10. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, to assist you with questions you have about your rights, the adverse benefit determination notice, or for assistance; and

11. A statement about the availability of language services on notices sent to addresses in applicable counties.

Internal Appeal Procedures

These appeal procedures shall be the exclusive procedures available to an employee or beneficiary who is dissatisfied with an eligibility determination, benefit award, or who is otherwise adversely affected by any action of the Administrative Office. These procedures must be exhausted before you ("Claimant") may file suit under Section 502(a) of ERISA. The Claimant may seek an appeal within 180 days of the receipt of an administrative denial/adverse benefit determination notice. Claimant shall be provided access to and copies of documents, records, and other information free of charge that are relevant to the claim, including any new or additional evidence considered by the Plan in connection with the claim, or any new or additional rationale upon which the final adverse benefit determination will be based, as soon as possible and sufficiently in advance of your appeal date so you can respond prior to that date. Claimant will have the opportunity to submit written comments, documents, records or any other information in support of the appeal. If the new information is received so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Claimant has a reasonable opportunity to respond.

PRE-SERVICE AND CONCURRENT CLAIMS
Please see the procedure under PRE-SERVICE CLAIMS above for instructions on contacting Blue Cross.

BENEFIT COVERAGE
There are no appeals of pre-service benefit coverage decisions since the Plan does not require pre-approval of benefit coverage. However, if you requested a benefit coverage determination as described above, you may appeal an adverse benefit coverage determination. Notwithstanding, such a request is not covered by the DOL regulations, including any time frame restrictions within which an appeal must take place.

POST-SERVICE CLAIMS
A Claimant may file a request for an appeal of any claim denied by the Administrative Office. Claims denied are subject to mandatory appeal procedures as follows:

The appeal will be heard by written submission no later than the Board of Trustees quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such case, an appeal decision will be made no later than the date of the second meeting following the plan's receipt of the request for appeal.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, the Claimant will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

Claimant will be notified of all post-service appeal decisions no later than five days after the decision is made. Claimant and the Trustees may agree to further extension of these time periods.

If the Trustees request, an in-person hearing will be held in which the Claimant and/or authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Trustees cannot decide an appeal from the written submission. Any such hearing will occur within the time frames identified above and is an example of a special circumstance.

INCOMPLETE CLAIMS
If the Claimant fails to follow the above-referenced procedures or does not provide sufficient information to decide an appeal, the Plan will notify the Claimant prior to the appeal date. The Claimant will have 45 days from receipt of the notification within which to provide the additional information. The Claimant and the Plan may agree to further extensions of this time period. All time periods for deciding an appeal mentioned above shall be tolled from the date on which the notification of any extension(s) is sent to the Claimant until the date on which the Claimant responds to the request for additional material.

NOTICE OF INTERNAL APPEAL DECISIONS/NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

All appeal decisions, whether adverse or not, will be provided to the Claimant in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information:

1. Date of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a reference to the specific Plan provision(s) on which the denial is based;

5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

6. A description of the Plan's standard used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request; and

    c. a discussion of the decision denying the claim;

7. An explanation of the External Review Processes and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA;

8. A statement that the diagnosis and treatment codes will be provided free of charge to you upon request;

9. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, for questions about your rights, the final internal adverse benefit determination notice, or for assistance; and

10. A statement about the availability of language services on notices sent to addresses in applicable countries.

INTERNAL APPEAL STANDARDS
The Trustees' review of a Claimant's request for appeal will be a *de novo* review. It will take into account all information submitted by the Claimant without regard to whether such information was submitted or considered in the administrative review phase.

The Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

The Trustees will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim under appeal.

Any entity reviewing the Trustees' decision may not consider evidence or facts that were not presented to the Trustees on appeal. The Trustees have the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

If the Plan fails to strictly adhere to the requirements of the Internal Appeal Procedures, except with respect to certain *de minimis*, non-prejudicial, good-faith errors, as may be permitted, the Claimant is deemed to have exhausted the Internal Appeal Procedures, and may initiate an external review and/or pursue any available remedies under Section 502(a) of ERISA. If the Plan asserts the *de minimis* exception, you may request a written explanation of the violation from the Plan and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that that the violation should not cause the Internal Appeal Procedures to be deemed exhausted.

External Review Process

PRE-SERVICE AND CONCURRENT CLAIMS
Please see the procedure under PRE-SERVICE CLAIMS above for instruction on contacting Blue Cross.

BENEFIT COVERAGE
There is no standard/expedited external review process available for pre-service benefit coverage decisions.

POST-SERVICE CLAIMS
If your claim is denied by the Board of Trustees under the Internal Appeal Procedures, you may request an independent, external review of certain claims (see below) by an Independent Review Organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct an external review. Your request for review must be made within four months after the date of receipt of a notice of the internal appeal decision/notice of final internal adverse benefit determination (or the notice of adverse benefit determination, if

applicable). The Plan will determine, within five business days, whether the claim is eligible for external review. Claims that are eligible for external review involve a medical judgment(s) (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, a determination regarding whether you are entitled to a reasonable alternative standard for a reward under a wellness program (if applicable), or a determination regarding compliance with nonquantitative treatment limitations under Internal Revenue Code Section 9812, and the regulations thereunder, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer; and any decision to rescind coverage.

You will be notified within one day after the Fund completes its preliminary review whether the claim is eligible for external review or, if not eligible, with the reason (s) for ineligibility and/or information/documentation needed to make the request complete and the contact information for the Employee Benefits Security Administration. If the claim is appropriate for external review, the Plan will refer the claim to an IRO. The Plan, through the Administrative Office, will contract with three IROs and will rotate assignments randomly among them. You may request copies of information relevant to your claim (free of charge) by contacting the Administrative Office at 1 (800) 824-4427 or 1 (562) 463-5080. Once the external review is initiated, you will also receive instructions on how to provide additional information to the IRO.

The IRO will conduct a *de novo* review of the claim. Notice of the final external review decision will be provided within 45 days after the IRO receives the request for the external review. The IRO's decision is binding on the Plan and the Claimant, except to the extent that other remedies may be available under Section 502(a) of ERISA or applicable state law.

Miscellaneous Benefit Claims and Appeals Procedures

The claim and appeal rights described in this section and any other rights or benefits described in this booklet cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals and Section 502(a) actions shall be made by you. You may authorize a representative to participate in the benefit claim process or to act on your behalf; however; the authorization must be made by you in writing or by electronic means to the Administrative Office.

The Benefit Claim and Appeal Procedures contained in this booklet are intended to be in compliance with ERISA Section 503, the Department of Labor Regulations 29 CFR 2560.503-1, and the Internal Claims and Appeals and External Review Processes implemented under Section 2719 of the Public Health Service Act, as enacted by the Patient Protection and Affordable Care Act and the regulations and guidance promulgated thereunder, and as such are intended to be reasonable and offer members a full and fair review process. Any omissions or oversights will be interpreted in accordance with the applicable law and its corresponding regulation(s).

TIME LIMITATION FOR A SECTION 502(A) LAWSUIT
A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination, or for eligible claims, the date of the notice of the final/external review decision.

Indemnity Prescription Drug Benefit Claims and Appeals Procedures

The benefits provided to you and your eligible dependents under the Indemnity Prescription Drug Plan will only be available if you comply with the following procedures.

ADMINISTRATIVE REVIEW

PRE-SERVICE CLAIMS FOR SPECIALTY DRUGS AND COMPOUND DRUGS THAT COST $50 OR MORE

A pre-service claim for a prescription drug is a claim that the Plan requires approval of in advance of purchasing the Prescription Drug. The Plan requires preauthorization for Prescription Drugs in only two areas: Specialty Drugs and compound drugs that cost $50 or more.

OptumRx, the Fund's current pharmacy benefit manager, will determine for the Plan whether a claimant's Specialty Drug claim or compound drug that costs $50 or more is medically necessary, appropriate for treating the underlying illness or injury, or experimental or investigational in nature.

There are two types of pre-service Specialty Drug claims: urgent and non-urgent.

URGENT CARE CLAIMS

An urgent care claim for Specialty Drugs or compound drugs that cost $50 or more is one that must be resolved more quickly than within the time periods for non-urgent care claims because if it is not so resolved it could: a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or b) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim for urgent care is to be determined by OptumRx applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Additionally, a claim will be considered an urgent care claim if a Physician with knowledge of the claimant's medical condition states that it is a claim involving urgent care.

Benefit Claim Procedures for Pre-Service Urgent Care Claims

Urgent care claims may be made orally or in writing by you, your Physician or other authorized representative. Urgent care claims must be made to OptumRx at 1 (800) 797-9791, if made orally.

Written requests should be addressed to OptumRx at:

OptumRx, INC.
d/b/a OptumRx
2300 Main Street
Irvine, California 92614

All claims must identify the name of the claimant; the specific medical condition or symptom; and the specific treatment, service, or product for which approval is sought. OptumRx will notify you of its decision within 72 hours of receipt of the claim. You and OptumRx may agree to an extension of this time period, but OptumRx may not unilaterally extend same. Notification may be oral, unless written notification is requested by you or your authorized representative. Any oral

notification by OptumRx will be followed up in writing within three days by U.S. mail, facsimile transmission or other electronic means.

Incomplete Claims
If you or your authorized representative fails to follow the above described procedures or does not provide sufficient information to decide a claim, OptumRx will notify you within 24 hours of the failure and inform you of the information necessary to file a complete claim. You will have a reasonable amount of time (at least 48 hours) to supply the additional information. When your complete claim filed with OptumRx, you will be notified of the determination, whether adverse or not, as soon as possible, but no later than 48 hours after the earlier of their receipt of the specified information or the end of the period afforded you to provide the additional information. You and OptumRx may agree to further extensions of these time periods.

NON-URGENT CARE CLAIMS
A non-urgent claim for Specialty Drugs or compound drugs that cost $50 or more is a claim that is not an urgent care claim.

Benefit Claim Procedures for Pre-Service Non-Urgent Care Claims
Non-urgent care claims may be made in writing by you, your Physician or other authorized representative. Non-urgent care claims must be addressed to OptumRx at:

OptumRx, INC.
d/b/a OptumRx
2300 Main Street
Irvine, California 92614

Non-urgent care claims will be handled in a similar manner as urgent care claims except that after filing a non-urgent care claim, OptumRx will notify you in writing of the decision no later than 15 days from the date the claim is filed. This period may be extended for an additional 15 days if prior to the expiration of the initial 15-day period you are notified of the circumstances requiring the extension of time and the date by which OptumRx expects to render a decision. You and OptumRx may agree to further extensions of these time periods.

Incomplete Claims
If you or your authorized representative fails to follow the above described procedures or do not provide sufficient information to decide a claim, OptumRx will notify you as soon as possible but no later than the end of the initial 15-day period. You will have 45 days from the receipt of the notice within which to provide the information. You and OptumRx may agree to further extensions of this time period. The time period for deciding such a claim shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

CONCURRENT CARE CLAIMS FOR SPECIALTY DRUGS AND COMPOUND DRUGS THAT COST $50 OR MORE
A concurrent care claim for Specialty Drugs or compound drugs that cost $50 or more is a claim for continued use of the Specialty Drug or compound drug that has been provided over a period of time or number of treatments which was previously approved and you have been informed of a

decision to reduce or terminate this ongoing course of treatment, or for a decision made regarding a request by you to extend a course of treatment beyond what has been approved.

Benefit Claim Procedures for Concurrent Care Claims
You will be notified by OptumRx of any reduction or termination of a previously approved Specialty Drug or compound drug prior to the date of the reduction or termination, allowing you sufficient time to appeal and obtain a determination on the appeal before the decision is to take effect.

If an urgent care concurrent claim is involved, any request by you to extend the course of treatment beyond the period of time or number of treatments previously approved will be decided by OptumRx/OptumRx as soon as reasonably possible. In any case, you will be notified of their determination within 24 hours of receipt of the request.

Incomplete Claims
Incomplete claims for concurrent care will be handled the same as incomplete pre-service urgent care or non-urgent care claims, as applicable (see page 118).

PRE-SERVICE OR CONCURRENT NON-SPECIALTY DRUG CLAIM, COMPOUND DRUGS THAT COST LESS THAN $50, OR CLAIMS FOR BENEFIT COVERAGE DETERMINATIONS
The Indemnity Prescription Drug Plan does not require preapproval of non-specialty drugs, compound drugs that cost less than $50, or claims for benefit coverage before other Prescription Drugs are purchased for either urgent or non-urgent pre-service or concurrent care claims. Therefore, the Department of Labor (DOL) Benefit Claims and Appeal Procedures regulations, including any time-frame restrictions within which to make these decision or determinations, do not apply. However, this does not mean the Plan will pay for the Prescription Drug expenses incurred when the claim is actually received. There are cost-sharing arrangements and other limitations and exclusions under the Plan that must be taken into consideration.

Notwithstanding, for convenience purposes only, if you and/ or your provider have any questions regarding a Prescription Drug claim, you may request, in writing, a pre-service or concurrent claim non specialty drug claim, non-specialty drug decision by sending your request to OptumRx, Inc., 2300 Main Street, Irvine, CA 92614. You may request a Plan determination for benefit coverage by sending your request to:

Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

OptumRx or the Administrative Office, as applicable, will respond within a reasonable time period. However, no such request will be viewed as a claim for benefits as defined in the DOL Benefit Claims and Appeal Procedures regulations. Please note that with regard to Benefit Coverage determination, the Plan cannot tell you or the provider the specific amount payable under the Plan until the drug is purchased or, in the rare instance, when you file a claim form for reimbursement after you have paid for a Prescription Drug.

POST-SERVICE CLAIMS
A post-service claim is a claim for a benefit under the Indemnity Prescription Drug Plan that is not a pre-service or concurrent care claim for a Specialty Drug or a compound drug that cost $50 or more (e.g., the Prescription Drug (Specialty or otherwise) has been purchased and you are requesting payment for the Prescription Drug under the Plan). Post-service claims include requests for actual payment by the Plan of any pre-service or concurrent claims for Specialty Drug or compound drugs that cost $50 or more. OptumRx handles post-service claims. If you file a post-service claim, OptumRx will notify you of its decision within 30 days of receipt of the claim.

Benefit Claim Procedures for Post-Service Claims
A post-service claim must be filed with OptumRx:

a. Obtain a claim form from the Administrative Office;

b. Complete Part I of the claim form;

c. Complete Part II (and attach an itemized billing); and

d. Provide the form along with the itemized billing to OptumRx at:

OptumRx
P.O. Box 29044
Hot Springs, AR 71903

For claims assistance, write OptumRx or call 1 (800) 797-9791.

Post-service claims must be submitted within 90 days after the date of purchase. No benefits will be payable if a post-service claim is submitted more than one year from the date of purchase.

OptumRx will notify you of its decision within 30 days of receipt of the claim. OptumRx is allowed one 15-day maximum extension if the claim decision cannot be made for reasons beyond the control of OptumRx and OptumRx notifies you prior to the expiration of the initial 30-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and OptumRx may also agree to further extensions of these time periods.

Incomplete Claims
If you fail to follow the above procedures or do not provide sufficient information to decide a claim, OptumRx will notify you within 30 days of the failure and inform you what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide the specific information. You and OptumRx may agree to further extensions of this time period. The time period for deciding a post-service claim shall be tolled from the date on which notification of the extension is sent to you until the date you respond to the request for additional information.

NOTICE OF CLAIMS DENIAL/NOTICE OF ADVERSE BENEFIT DETERMINATION
If any claim (pre-service, concurrent care, or post-service) is denied in whole or in part on the basis of eligibility or that the benefits will not be paid under the Plan because they were not pre-

approved, not necessary, not covered etc., or if your coverage is rescinded, you will be provided with a notice of denial/adverse benefit determination, which will contain:

1. Date of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, if applicable, and a reference to the specific Plan provision(s) on which the denial is based;

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records and other information relevant to the claimant's claim for benefits;

6. A description of OptumRx/OptumRx's or the Plan's standard, as applicable, used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion, will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request;

7. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

8. An explanation of the Internal Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Internal Appeal Procedures (see below);

9. In the case of pre-service or concurrent urgent care Specialty Drug claim, a description of the expedited appeal review process available for such a claim;

10. A statement that the diagnosis and treatment codes, and their corresponding meanings, will be provided, if applicable, free of charge to you upon request;

11. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, to assist you with questions you have about your rights, the adverse benefit determination notice, or for assistance; and

12. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL PROCEDURES

These appeal procedures shall be the exclusive procedures available to an employee or beneficiary who is dissatisfied with an eligibility determination, benefit award or who is otherwise adversely affected by any action of OptumRx, the Administrative Office, or the Trustees, as applicable. These procedures must be exhausted before you ("Claimant") may file suit under Section 502(a) of ERISA. Claimant may seek an appeal within 180 days of receipt of an administrative denial/adverse benefit determination notice. Claimant shall be provided access to and copies of documents, records and other information free of charge that are relevant to the claim, including any new or additional evidence considered by OptumRx or the Trustees, as applicable, in connection with the claim, or any new or additional rationale upon which the final adverse benefit determination will be based, as soon as possible and sufficiently in advance of your appeal date so you can respond prior to that date. Claimant will have the opportunity to submit written comments, documents, records or any other information in support of the appeal. If the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time that you have a reasonable opportunity to respond.

PRE-SERVICE CLAIMS FOR SPECIALTY DRUGS AND COMPOUND DRUG THAT COST $50 OR MORE

Claimant may file a request for an appeal of any OptumRx pre-service claim decision on Specialty Drugs or compound drug that cost $50 or more. There are two types of pre-service appeals: urgent and non-urgent. Pre-service claim denials are subject to one level of mandatory appeal to OptumRx.

Appeal Procedures for Pre-Service Urgent Claims

Claimant may file a request for an expedited urgent care appeal to OptumRx either orally at 800-797-9791 or in writing by you, your Physician, or authorized representative to OptumRx at:

OptumRx, INC.
d/b/a OptumRx
2300 Main Street
Irvine, California 92614

Information transmitted between OptumRx and Claimant shall be by telephone, facsimile transmission, or other expeditious means. Claimant will be notified of the appeal decision, whether adverse or not, as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the request for an appeal. If the notification is made orally, a written decision will also be provided within three days. You and OptumRx may agree to further extensions of these time periods.

Appeal Procedures for Pre-Service Non-Urgent Care Claims

Claimant may file a request for a non-urgent care appeal in writing to OptumRx at:

OptumRx, INC.
d/b/a OptumRx
2300 Main Street
Irvine, California 92614

Claimant will be notified of the appeal decision, whether adverse or not, no later than 30 days after receipt of the written appeal.

Concurrent Care Claims for Specialty Drugs or Compound Drugs That Cost $50 or More
Claimant may file a request for an appeal of any OptumRx concurrent care claim decision on Specialty Drugs or compound drugs that cost $50 or more. Concurrent care claim denials to one level of mandatory appeal to OptumRx.

Appeal Procedures for Concurrent Care Claims
If the appeal involves a concurrent care urgent or non-urgent care claim, please use the appeal procedures for pre-service claims on pages 122 to 123.

PRE-SERVICE OR CONCURRENT CARE CLAIMS FOR NON-SPECIALTY DRUGS, COMPOUND DRUGS THAT COST LESS THAN $50, OR CLAIMS FOR BENEFIT COVERAGE DETERMINATIONS
There are no appeals of pre-service or concurrent care non-Specialty Drug claims, compound drugs that cost less than $50, or benefit coverage decisions since the Plan does not require pre-approval of non-Specialty Drugs, compound drugs that cost less than $50, or benefit coverage. However, if you requested a pre-service or concurrent same review of the claims/determinations, as described above, you may appeal an adverse non specialty drug or benefit coverage determination. Notwithstanding, such a request is not covered by the DOL regulations, including any time frame restrictions within which an appeal must take place or an appeal decision is made.

POST-SERVICE CLAIMS
Claimant may file a request for an appeal of any post-service claim denial. Post-service claim denials are subject to one-level of mandatory appeal.

Appeal Procedures for Post-Service Claims
Claimant may file a request for a post-service claim appeal in writing to:

Board of Trustees
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

The appeal will be heard by written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be

made no later than the date of the second meeting following the Plan's receipt of the Claimant's request.

If there are no special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, the Claimant will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

Claimant will be notified of all post-service appeal decisions no later than five days after the decision is made. Claimant and the Board of Trustees may agree to further extension of these time periods.

If the Trustees request, an in-person hearing will be held in which the Claimant and/or authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Trustees cannot decide an appeal from the written submission. Any such hearing will occur within the time frames identified above and is an example of a special circumstance.

Incomplete Claims
If the Claimant fails to follow the above-referenced procedures or does not provide sufficient information to decide an appeal, OptumRx or the Administrative Office, as applicable, will notify the Claimant prior to the appeal date. The Claimant will have 45 days from receipt of the notification within which to provide the additional information. The Claimant and OptumRx or the Administrative Office, as applicable, may agree to further extensions of this time period. All time periods for deciding an appeal mentioned above shall be tolled from the date on which the notification of any extension(s) is sent to the Claimant until the date on which the Claimant responds to the request for additional material.

Notice of Internal Appeal Decision/Notice of Final Adverse Benefit Determination
All appeal decisions (pre-service, concurrent care or post-service claims), whether adverse or not, will be provided to the Claimant in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information:

1. Date of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, if applicable, and a reference to the specific Plan provision(s) on which the denial is based;

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records and other information relevant to the claimant's claim for benefits;

6. A description of OptumRx/OptumRx's or the Plan's standard, as applicable, used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion, will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request;

    c. A discussion of the decision denying the claim.

7. An explanation of the External Appeal Procedures and a statement of the Claimant's right to bring action under Section 502(a) of ERISA;

8. A statement that the diagnosis and treatment codes, and their corresponding meanings, will be provided, if applicable, free of charge to you upon request;

9. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, to assist you with questions you have about your rights, the adverse benefit determination notice, or for assistance; and

10. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL STANDARDS

OptumRx's or the Trustees' review, as applicable, of a Claimant's request for appeal will be a *de novo* review. This review will include a review and consideration of all information submitted by the Claimant without regard to whether such information was submitted or considered during the administrative claim review process.

OptumRx or the Trustees, as applicable, will consult with a health care professional who has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

OptumRx or the Trustees, as applicable, will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of OptumRx or the Trustees, as applicable, in connection with the claim under appeal.

Any entity reviewing OptumRx's or the Trustees' decision, as applicable, may not consider evidence or facts that were not presented to OptumRx or the Trustees on appeal. OptumRx or the Trustees, as applicable, have the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

If OptumRx or the Trustees, as applicable, fails to strictly adhere to the requirements of the Internal Appeal Procedures, except with respect to certain *de minimis*, no prejudicial, good-faith errors, as may be permitted, the Claimant is deemed to have exhausted the Internal Appeal Procedures, and may initiate an external review and/or pursue any available remedies under Section 502(a) of ERISA. If OptumRx or the Trustees, as applicable, asserts the *de minimis* exception, you may request a written explanation of the violation from OptumRx or the Trustees, as applicable, and OptumRx or the Trustees, as applicable, must provide such explanation within 10 days, including a specific description of their basis, if any, for asserting that the violation should not cause the Internal Appeal Procedure to be deemed exhausted.

STANDARD EXTERNAL REVIEW PROCESS

If your Prescription Drug claim (pre-service, concurrent, or post-service) is denied by OptumRx or the Trustees, as applicable, under the Internal Appeal Procedures, you may request an independent, external review of certain claims (see below) by an Independent Review Organization (IRO) that is accredited by the URAC or by a similar nationally-recognized accrediting organization to conduct external reviews. Your request for review must be made within four months after the date of receipt of a notice of the internal appeal decision/notice of final internal adverse benefit determination (or the notice of adverse benefit determination, if applicable). OptumRx or the Administrative Office, as applicable, will determine, within five business days, whether the claim is eligible for external review. Prescription Drug claims that are eligible for external review involve medical judgment(s) (including, but not limited to, those based on medical necessity, appropriateness, or effectiveness of a covered Prescription Drug benefit, a determination that a covered Prescription Drug is experimental or investigational, or a determination regarding compliance with nonquantitative treatment limitations under Internal Revenue Code Section 9812, and the regulations thereunder, which the application of medical management techniques), as determined by the external reviewer; and any decision to rescind coverage.

You will be notified within one day after OptumRx or the Administrative Office, as applicable, completes its preliminary review whether the claim is eligible for external review or, if not eligible, with the reasons for ineligibility and/or information/documentation needed to make the request complete and the contact information for the Employee Benefits Security Administration. If the claim is appropriate for external review, OptumRx or the Administrative Office, as applicable, will refer the claim to an IRO. OptumRx or the Trustees, through the Administrative Office, as applicable, will contract with three IROs and will rotate assignments randomly among them. You may request copies of information relevant to your claim (free of charge) by contacting OptumRx at 1 (800) 797-9791 or the Administrative Office at 1 (800) 824-4427 or 1 (562) 463-5080, as applicable. Once the external review is initiated, you will also receive instructions on how to provide additional information to the IRO.

The IRO will conduct a *de novo* review of the claim. Notice of the final external review decision will be provided within 45 days after the IRO receives the request for the external review. The IRO's decision is binding on the Plan and the Claimant, except to the extent that other remedies may be available under Section 502(a) of ERISA or applicable state law.

EXPEDITED EXTERNAL REVIEW PROCESS

If your claim (pre-service or concurrent care claim for a Specialty Drug or compound drug that costs $50 or more) is denied by OptumRx, a Claimant may make a request for an expedited external review with OptumRx at the time the Claimant receives: (a) an adverse benefit determination, if the adverse benefit determination involves a medical condition of the Claimant for which the time frame for completion of an expedited urgent care appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function or (b) the Claimant has filed a request for an expedited internal appeal or a final internal adverse benefit determination, if the Claimant has a medical condition where the time frame for completion of a Standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns a Specialty Drug or compound drug that costs $50 or more used during the course of a Claimant receiving emergency services, when the Claimant has not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, OptumRx must determine whether the request meets the reviewability requirements set forth under the Standard External Review Procedures (see above). OptumRx must immediately send a notice that meets the requirements set forth under the Standard External Review Procedures (see above) to the Claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, OptumRx will assign an IRO pursuant to the requirements set forth in the Standard External Review Procedures (see above). OptumRx must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the internal benefit claims and appeal process.

The IRO must provide notice of its decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and OptumRx.

MISCELLANEOUS BENEFIT CLAIM AND APPEAL PROCEDURES

The claim and appeal rights described in this section and any other rights or benefits described in this booklet cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals and Section 502(a) actions shall be made by you. You may authorize a representative to participate in the benefit claim process or act on their behalf; however; the authorization must be made by you in writing or by electronic means to OptumRx or the Administrative Office, as applicable.

The Benefit Claim and Appeal Procedures contained in this booklet are intended to be in compliance with ERISA Section 503, the Department of Labor Regulations 29 CFR 2560.503-1, and the Internal Claims and Appeals and External Review Processes implemented under

Section 2719 of the Public Health Service Act, as enacted by the Patient Protection and Affordable Care Act and the regulations and guidance promulgated thereunder, and as such are intended to be reasonable and offer members a full and fair review process. Any omissions or oversights will be interpreted in accordance with the applicable law and its corresponding regulation(s).

TIME LIMITATION FOR A SECTION 502(A) LAWSUIT
A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination, or for eligible claims, the date of the notice of the final/external review decision.

Indemnity Dental and Vision Care Claims

There are no pre-approval programs for dental or vision care claims. All claims for benefits and appeals thereon for these benefits will be treated the same as post-service medical claims as described herein. Please see the foregoing if you have any indemnity dental or vision claims.

HMO/Prepaid Plan Benefit Claims

The benefit claim and appeals procedures for the HMO and prepaid plans are set forth in their respective sections in this booklet.

Life and AD&D Insurance Claims

The benefit claim procedures for the Life and AD&D insurance are set forth in the Life and AD&D section of this booklet.

INFORMATION ABOUT THE ADMINISTRATION OF THE PLAN

1. **Name of Plan**

   The name of the Plan is the Southern California Lumber Industry Welfare Fund, Managed Care Plan ("Plan").

   The Plan is administered by the Board of Trustees of the Southern California Lumber Industry Welfare Fund pursuant to the terms of a Trust Agreement.

2. **Name, Address and Telephone Number of the Board of Trustees**

   Southern California Lumber Industry Welfare Fund
   Benefit Programs Administration
   1200 Wilshire Boulevard, Fifth Floor
   Los Angeles, CA 90017-1906

   Telephone: (562) 463-5080
   (800) 824-4427

3. **Identification Numbers**

   The taxpayer identification number assigned to the Fund by the Internal Revenue Service is 95-6035120. The plan number is 501.

4. **Type of Plan**

   The Plan is a group health plan as defined by ERISA Section 733. The Plan provides medical, prescription drug, dental, vision, and life and accidental death and dismemberment benefits for active employees only.

5. **Type of Administration**

   The Plan is administered by the Board of Trustees utilizing the services of Benefit Programs Administration ("BPA"), a contract administrative manager.

6. **Name, Address, and Telephone Number of the Plan Administrator**

   See item 2 above.

7. **Agent for Service of Legal Process**

Southern California Lumber Industry Welfare Fund
Administrative Office
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906

8. **Board of Trustees**

The Trustees serving as of the date of the printing of this booklet are as follows:

EMPLOYER TRUSTEES

John "Bogey" Nichols
Reliable Wholesale Lumber
7600 Redondo Circle
Huntington Beach, CA 92648

Brent K. Bergland
1125 Wiladonda Drive
La Canada Flintridge, CA 91011-2357

Vince Schlachter
Systechs
249 W. Baywood Ave. #B
Orange, CA 92865

Ernie Martinez
Performance Contracting
1822 Main St., Suite A
San Diego, CA 92113

UNION TRUSTEES

Patrick McGinn
Southwest Carpenters Training Fund
533 South Fremont Ave., Suite 401
Los Angeles, CA 90071-1706

Fernando Rojas
Cabinet Makers, Millmen & Industrial
Carpenters Local 721
10015 Rose Hills Road, Suite 100
Whittier, CA 90601

James K. Bernsen
11322 Kensington Road
Los Alamitos, CA 90720

Oscar Cordova
Cabinet Makers, Millmen & Industrial
Carpenters Local 721
10015 Rose Hills Road, Suite 100
Whittier, CA 90601

9. **Description of Collective Bargaining Agreement(s)**

a. The Plan is funded primarily from employer contributions. Employers make contributions for bargaining unit employees as required by the terms of various collective bargaining agreements. Generally, the collective bargaining agreements provide that the employer will contribute at a specified contribution rate set by the Board of Trustees per employee per month. By signing special agreements some employers may also make contributions for non-bargaining unit employees in the same amount that is paid for bargaining unit employees. Contribution rates and benefit levels provided by the Trust Fund are determined solely by the Board of Trustees and are not subject to the negotiating process.

b. Copies of the applicable collective bargaining agreements will be furnished by the Trustees, upon written request addressed to the Administrative Office. The Trustees may impose a reasonable charge for these copies. Also, copies are available for examination at the Administrative Office upon 10 days advance written notice. Copies are also available at the Local Union Office.

10. **Participation, Eligibility, and Benefits**

Indemnity Medical Plan

Participation	See pages 1 to 5 and page 30 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See pages 31 to 50 of this booklet for the summary of these benefits.
Cost sharing	See pages 31 to 32 of this booklet.
Annual and lifetime caps	See page 33 of this booklet.
General limitations and exclusions	See pages 42 to 44 of this booklet.
Preventive services	See page 32 of this booklet.
Medical tests, devices, and procedures	See page 32 of this booklet
Hospital and Physician network providers	See pages 36 to 38 of this booklet.

Note: A listing of the Hospital and Physician network providers is supplied to you and your eligible beneficiaries automatically when you enroll in the Plan. Directories can also be obtained free of charge upon request to the Administrative Office or electronically from Blue Cross at 1-800-824-4427.

Out-of-network provider Reimbursement	See pages 32 to 36 of this booklet.
Emergency care benefits and Limitations	See page 32 and 35 of this booklet.
Preauthorization and utilization review	See pages 38 to 39 of this booklet.
Prescription drugs	See pages 88 to 96 of this booklet.

HMO Medical Plan (Kaiser)

Participation	See pages 1 to 5 and page 51 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See respective pages in this booklet for the HMO summary and benefits. The descriptions will include cost sharing provisions, annual and lifetime caps (if any), general limitations and exclusions, preventative services covered, medical tests, devices and procedures, covered Hospital and network providers, out-of-network reimbursement provisions (if any), emergency care benefits and limitations and preauthorization and utilization review requirements (if any).

Dental Indemnity Plan

Participation	See pages 1 to 5 and pages 70 to 71 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See pages 71 to 75 of this booklet for the summary of these benefits.
Cost sharing	See pages 71 to 75 of this booklet.
Annual and lifetime caps	See pages 71 of this booklet.
General limitations and exclusions	See page 75 to 76 of this booklet.
Preventive services	See page 71 of this booklet.
Tests, devices, and procedures	See pages 71 to 75 of this booklet.

Prepaid Dental Plan (DeltaCare USA)

Participation	See pages 1 to 5 and page 79 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See pages 80 to 81. The descriptions will include cost sharing provisions, annual and lifetime caps (if any),

	general limitations and exclusions, preventative services covered, out-of-network reimbursement provisions (if any), emergency care benefits and limitations and preauthorization and utilization review requirements (if any).
Prescription Drug Program	
Participation	See page pages 1 to 5 and page 88 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See pages 88 to 96 of this booklet for the summary of these benefits.
Cost sharing	See page 88 of this booklet.
General limitations and exclusions	See pages 93 to 95 of this booklet.
Network providers	See pages 89 to 90 of this booklet.
Out-of-network reimbursement	See pages 88 to 96 of this booklet.
Availability of new and existing drugs	See pages 88 to 96 of this booklet.
Vision Care Program	
Participation	See pages 1 to 5 and pages 97 to 100 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 and pages 97 to 100 of this booklet for the summary of these rules.
Benefits	See pages 97 to 100 of this booklet for the summary of these benefits.
Cost sharing	See page 97 of this booklet.
Annual and lifetime caps	See page 97 of this booklet.
General limitations and exclusions	See page 98 of this booklet.
Preventive services	See page 97 of this booklet.

Life and Accidental Death and Dismemberment Plan

Participation	See pages 1 to 5 and pages 101 to 108 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 and pages 101 to 108 of this booklet for the summary of these rules.
Benefits	See pages 101 to 108 of this booklet for the summary of these benefits.

Dependent Life Insurance Plan

Participation	See pages 105 to 108 of this booklet for the summary of these rules.
Eligibility	See pages 1 to 5 of this booklet for the summary of these rules.
Benefits	See page 101 of this booklet for the summary of these benefits.

Note: You may also request a copy of the Plan's Qualified Medical Child Support Order (QMCSO) written procedures.

11. **Circumstances Which May Result in Disqualification, Ineligibility, or Denial, Loss, Forfeiture, Suspension, Offset, Reduction, or Recovery of Benefits**

An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

a. The employee's failure to work the Required Hours to maintain eligibility. See the eligibility rules set forth on pages 1 to 5 of this booklet.

b. The failure of your employer to report the hours and remit the required contributions on your behalf to the Trust Fund.

c. In the case of beneficiaries who are dependents of an eligible employee, the failure of your employer to remit the required contributions on their behalf to the Trust Fund.

d. The failure of your employer to enter into a signed written collective bargaining agreement, or renewal thereof, with a participating labor organization.

e. In the case of beneficiaries who are dependents of an eligible employee, they may become ineligible if (a) they are no longer dependents or (b) have attained the disqualifying age. See dependent eligibility rules set forth on pages 2 to 5 of this booklet.

f. You or your eligible dependents do not elect COBRA continuation coverage upon a qualifying event, or if you or your dependents elect COBRA continuation coverage,

and the required payments are not made timely or the COBRA extension period expires. See pages 7 to 15 of this booklet.

g. If you or your eligible dependents are paid benefits in error and the Plan is not reimbursed, the Plan may offset future claims payments by the amount that was not repaid.

h. If you or your dependent is injured by a third party and a lawsuit is being pursued or will be pursued.

i. If expenses you incur are not covered, in whole or in part, under the Plan of benefits you and your eligible dependent(s) have chosen. See the general and specific limitations and exclusions for the Indemnity Medical Plan on pages 42 to 44 of this booklet.

j. See also item 14 below.

An employee or beneficiary who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

a. The failure of the employee or beneficiary to timely file a claim for benefits.

b. The failure of the employee or beneficiary to file a complete and truthful benefit application.

c. If the employee or beneficiary has other group insurance coverage, benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two Plans.

d. If the loss for which the claim is being made is subject to an exclusion of, or limitation of the benefit plan/insurance policy or health plan agreement.

e. If you or your dependents are paid benefits in error and the Plan is not reimbursed, the Plan may offset future claims payments by the amount that was not repaid.

f. If you or your dependent is injured by a third party and a claim or lawsuit is being pursued or will be pursued against a third party. In the event a claim or lawsuit is being pursued against a third party (including a workers' compensation claim, lawsuit, etc.), and the Fund is unaware of the claim, lawsuit, etc. and consequently pays claims in error, and you and/or your dependent recover money from a third party (including through workers' compensation/employer insurance, etc.), then you and/or your dependent must refund the Fund 100% of the claims paid, which may be up to the total amount recovered from the third party (or through workers' compensation/employment insurance, etc.), and there will be no offset for attorney's fees under any legal theory whatsoever, including, but not limited to, the make whole doctrine and common fund doctrine.

g. If you or your dependent is injured by a third party and a claim or lawsuit is bring pursued or will be pursued against a third party. In the event a claim or lawsuit is being pursued against a third party (including a workers' compensation claim, lawsuit, etc.), and the Fund is unaware of the claim, lawsuit, etc. and consequently pays claims in error, and you and/or your dependent recover money from a third party (including through workers' compensation/employer insurance, etc.), then you and/or your dependent must refund the Fund 100% of the claims paid, which may be up to the total amount recovered from the third party (or thorough workers' compensation/employment insurance, etc.), and there will be no offset for attorney's fees under any legal theory whatsoever, including but not limited to, the make whole doctrine and common fund doctrine.

h. See also item 14 below.

The information provided in item 11 is intended as a summary of circumstances that would result in a denial of eligibility or benefits. It is not intended to be an exhaustive list of all such circumstances. Please refer to the remainder of this Plan Booklet for additional circumstances.

12. **COBRA Rights**

You and your eligible dependents' COBRA rights are summarized on pages 7 to 15 of this booklet.

13. **Compliance with ERISA and the Internal Revenue Code**

The Trustees believe that the Plan fully complies with the Employee Retirement Income Security Act (ERISA) of 1974 as amended, the Internal Revenue Code and any other applicable law. Any omissions or oversights will be resolved in accordance with the statute(s) or other applicable laws.

14. **Plan Amendments or Plan Termination**

The Trustees reserve the right to interpret and apply the provisions of the benefit plan(s) created and administered by them, and to, also, amend the benefit plan(s), in whole or in part, in their discretion. The Trustees may also in their discretion terminate the benefit plans(s), in whole or in part, at any time if such action(s) is deemed necessary by the Trustees. You and your eligible dependents will be provided with a summary material modification (SMM) of any material no later than 60 days after the adoption date of the modification or change. Any modification or change in the Summary of Benefit Coverage (SBC) will be provided at least 60 days in advance of the adoption date of the modification change. If the benefit plan(s) is terminated, the Participants will be notified as soon as reasonably possible. In the event of a termination of all benefit plans, Article XII, Section 3 of the Trust Agreement governs the disbursement of any remaining monies or assets. However, no remaining monies or assets will be recoverable by any participating employer, employer organization or labor organization.

15. **Source of Contributions**

a. Contributions are made primarily by the participating employers under collective bargaining agreements. The obligations and terms of such are further summarized in item 9 above. Employee self-payments are also allowed under the Managed Care Plan's COBRA and USERRA continuation coverage. Provisions for these payments are described on pages 7 to 16 of this booklet.

b. A complete list of participating employers and labor organizations may be obtained by participants and beneficiaries upon written request to the Administrative Office and is available for examination upon 10 days advance written notice at the Administrative Office. The Trustees may impose a reasonable charge for the list of participating employers and labor organizations.

16. **Plan Year**

The Plan Year is January 1 through December 31.

17. **Entities Used for Accumulation of Assets, Employer Contributions, and Payment of Benefits**

All employer contributions are received by, collected, and deposited with Union Bank of California (commercial bank) or Wells Fargo (custodial bank). The funds are then used to pay premiums to the insurance carriers and providers of services, pay benefits directly when applicable, pay expenses of administration, and to provide reserves. All COBRA and USERRA payments are received by the Administrative Office and then deposited with Union Bank of California (commercial bank) or Wells Fargo (custodial bank).

18. **Insurers and Providers of Service to the Plan**

Benefits Program Administration (BPA) provides third party administration to the Plan. Some benefits under this Plan are provided through a Health Maintenance Organization ("HMO"), prepaid plans, and insurance companies as indicated by an asterisk (*). Premiums are paid to the HMOs, prepaid plans, and insurance companies for this coverage on behalf of you and your eligible dependents. Any claims dispute involving an HMO, prepaid plan, or insurance company must initially be handled directly with the appropriate entity as described in this booklet.

The Indemnity Medical Plan, the Dental Indemnity Plan, the Prescription Drug and the Vision Plan are self-funded. Benefit Programs Administration (BPA) administers the payment of claims for the Indemnity Medical Plan, the Dental Indemnity Plan, and the Vision Plan. OptumRx administers payment of claims for the Prescription Drug Plan.

The insurance carriers and providers of service to the Plan for the benefits described in this booklet are:

Life Insurance and Accidental Death and Dismemberment Benefits

The Union Labor Life Insurance Company
180 Montgomery Street, Suite 1100
San Francisco, CA 94104
(fully insured, including administration)

Hospital, Medical, and Surgical Benefits

Southern California Lumber Industry Welfare Fund
Managed Care Plan
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(self-insured and administered by BPA)

Kaiser Foundation Health Plan, Inc.*
Regional Offices, Southern California
393 East Walnut Street
Pasadena, CA 91188-8110
(fully insured, including administration)

Utilization Review

Anthem Blue Cross of California
21555 Oxnard Street
Woodland Hills, CA 91365

Preferred Provider Organization

Anthem Blue Cross of California
21555 Oxnard Street
Woodland Hills, CA 91365

Dental Benefits

Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(self-insured and administered by BPA)

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703-8579
(fully insured, including administration)

Prescription Drug Benefits (Retail and Mail Order)

OptumRx
3515 Harbor Boulevard
Costa Mesa, CA 92626
(self-insured and administered by BPA and OptumRx)

Vision Benefits

Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(self-insured and administered by BPA)

19. **Benefit Claim and Appeal Procedures**

See "Benefit Claim and Appeal Procedures" section on pages 109 to 128 of this Plan Booklet.

20. **Statement of ERISA Rights**

Participants in the Southern California Lumber Industry Welfare Fund's Managed Care Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other locations (worksites or union offices), all plan documents, including insurance contracts, 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 Pension and Welfare Benefits Administration.

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

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

b. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may

have to pay for such coverage. Review this summary plan description and the documents governing the plan for your COBRA continuation coverage rights.

c. Prudent Actions by Plan Fiduciaries

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

d. Enforce Your Rights

If your claim for a welfare benefit is denied, 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 state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the 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.

e. 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, 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.

This booklet is a Summary Plan Description and Plan Document required by federal law. Of necessity, this booklet describes in general terms the plans provided through the Trust. It is not to be considered the contract of insurance. All statements made in this booklet are subject to the complete terms of the Southern California Lumber Industry Welfare Fund's Managed Care Plan and the master service agreements issued by Kaiser Foundation, Delta Dental Plan, OptumRx, and the group insurance policy issued by The Union Labor Life Insurance Company, and all amendments to their respective documents. Please refer to the master policies and agreements for a complete and detailed description of the coverage.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration, should be referred to the Administrative Office of the Fund:

Administrative Office
Southern California Lumber Industry Welfare Fund
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5080
(800) 824-4427

No representations made to a participant, Physician, dentist, Hospital or other medical provider concerning eligibility, entitlement to benefits, or the amount of benefits payable are binding against the Trust Fund unless the representations are made in writing by the Board of Trustees or the Administrative Manager or are made orally by Blue Cross in an urgent care claim situation under the Department of Labor claims procedure regulations.

The only parties authorized to answer questions concerning the Trust Fund and Plan are the Board of Trustees and the Administrative Manager. No participating employer, employer association, or labor organization, nor any individual employed thereby, has any such authority.