SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 1
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on May 5, 2011, did adopt the following amendment to the Select Choice Plan in order to clarify plan changes as stated in the Participant Notice approved by the Board of Trustees at a meeting on October 26, 2010, in compliance with the Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended, and the regulations promulgated thereunder (subject to further guidance issued by the applicable federal agencies). This Amendment is effective January 1, 2011.

1. Under the "Eligibility" section, "Definition of Eligible Dependents" subsection, Item No. 3 is revised as follows:

"**ELIGIBILITY**

* * *

DEFINITION OF ELIGIBLE DEPENDENTS

* * *

3. The employee's children, as defined below, who are under age 26. However, with respect to plan years beginning before January 1, 2014, as long as this Plan continues to be a "grandfathered plan," as that term is defined under Patient Protection and Affordable Care Act of 2010 and the regulations promulgated thereunder, children ages 19 to 26 who are eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent are not eligible for dependent coverage under this Plan."

* * *

2. Under the "Eligibility" section, the "Dependent Children" subsection is revised as follows:

"ELIGIBILITY

* * *

Dependent Children

Dependent coverage must be continuous. (But see special enrollment provisions and waiver provisions on pages 15-19.)

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...."

* * *

3. Under the "Eligibility" section, "Dependent Children" subsection, the eighth paragraph (regarding medical leave for dependents with full-time student status) is deleted in its entirety. The remaining paragraph is now the eighth paragraph.

4. Under the "Special Enrollment Rights Under HIPAA" section, "You and/or Your Existing Dependents" subsection, the references to "lifetime limit on benefits" under the first paragraph (Item No. 2) and the second paragraph, are revised to add a parenthetical as follows: "lifetime limit on benefits (to the extent a lifetime limit is applicable)."

5. Under the "Special Enrollment Rights Under HIPAA" section, a new subsection is added after the "New Dependents" subsection and before the "Miscellaneous" subsection as follows:

"SPECIAL ENROLLMENT RIGHTS UNDER HIPAA

* * *

Special Enrollment Rights Under PPACA

Under the Patient Protection and Affordable Care Act of 2010 ("PPACA"), special enrollment opportunities are available for eligible adult dependent children up to age 26; and for participants who previously reached a Lifetime Maximum Benefit under the Select Choice Plan's Indemnity Medical Plan (i.e., before the Plan was amended to eliminate the Lifetime Maximum Benefits), as applicable, and continue to be eligible for coverage under the Plan. A 30-day special enrollment period (with enrollment effective January 1, 2011) and notice of same was provided to participants. Adult dependent children up to age 26 and participants who previously reached a lifetime limit (as applicable) who do not enroll during the special enrollment period will also be permitted to enroll during the Plan's annual open enrollment from November 1st to November 30th each year, subject to meeting the other eligibility rules."

6. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to read as follows:

"SUMMARY OF BENEFITS

BENEFIT	INDEMNITY MEDICAL PLAN COVERAGE
Lifetime Maximum Benefit (while otherwise eligible) for essential health benefits	None
Calendar Year Maximum Benefit (while otherwise eligible) for essential health benefits	$750,000, effective January 1, 2011; $1,250,000, effective January 1, 2012; $2,000,000, effective January 1, 2013; and None, effective January 1, 2014.

	(Unless a waiver is applied for and granted by the Department of Health and Human Services.)	
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Professional Services		
* * *		
Physical Therapy, Chiropractic Services, and Acupuncture	80% of Contract Rate	60% of Covered Charges (40 visits per year)
* * *		
Mental Health & Substance Abuse * * * Inpatient	 * * * 80% of Contract Rate (45 day maximum per year)	 * * * 60% of Covered Charges (45 day maximum per year)"

7. Under the "Indemnity Medical Plan" section, the "Lifetime Maximum Benefit (While Otherwise Eligible)" subsection is revised to read as follows:

"**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; limits on number of visits, etc.; or per-visit dollar limits; still apply to specific periods, conditions, or types or levels of care. For example, per-day dollar maximums for skilled nursing, extended care, and convalescent care; 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 per-visit dollar maximums for outpatient mental health and substance abuse services (and other calendar year visit/confinement limitations described below) are applicable.

8. Under the "Indemnity Medical Plan" section, the "Calendar Year Maximum Benefit (While Otherwise Eligible)" subsection is revised to read as follows:

"**CALENDAR YEAR MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

The calendar year maximum dollar benefit for essential health benefits is $750,000 per person, effective January 1, 2011; $1,250,000 per person, effective January 1, 2012; $2,000,000 per person, effective January 1, 2013; and none, effective January 1, 2014 (unless a waiver is applied for and granted by the Department of Health and Human Services).

Calendar year visit/confinement and day limitations are applicable to well-baby care; out-of-network physical therapy, chiropractic services, and acupuncture; and inpatient mental health and substance abuse benefits."

9. Under the "Indemnity Medical Plan" section, "Maximum Covered Charges" subsection, Paragraph 1 entitled "Hospital/Facility Covered Charges (Inpatient)" is revised to delete the Maximum Covered Charge for "(Level 3) Psychiatric/Mental Health and Substance Abuse" benefits.

10. Under the "Indemnity Medical Plan" section, "Maximum Covered Charges" subsection, Paragraph 3 entitled "Physical Therapy, Chiropractic, and Acupuncture Maximums" is revised to delete the phrase "will not exceed $60 per treatment day and."

11. Under the "Indemnity Medical Plan" section, "Limitations and Exclusions" subsection, Paragraph 26 is revised as follows:

"**LIMITATIONS AND EXCLUSIONS**

* * *

26. Services related to or complications resulting from a service that is not covered by the Plan. (To the extent this provision limits treatment for pre-existing conditions; it shall not apply to children ages 0 through 18.)"

12. Under the "Scheduled Dental Plan" section, the "Summary of Dental Benefits" subsection is revised as follows:

"**SUMMARY OF DENTAL BENEFITS**

BENEFITS	**SCHEDULED DENTAL PLAN COVERAGES**
Lifetime Maximum (except Orthodontics)	None
Calendar Year Maximum	$1,500*
*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. **Deductible**	None"
* * *	

13. Under the "Prescription Drug Benefits" section, "Covered Drugs and Supplies" subsection, the age limit (i.e., "up to age 25") in Item No. 6 is changed to "up to age 26."

14. Under the "Vision Benefits" section, the "Summary of Benefits" subsection is revised as follows:

"**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 pediatric (ages 0 through 18) vision services have no annual dollar maximums. The scheduled maximum amounts that the plan pays, listed above, continue to apply to eye exams, frames, and lenses for children ages 0 through 18; however, the frequency (i.e., once per calendar year) limits listed above will not apply. Pediatric vision services do not include contact lenses; therefore the maximum benefit of $125 per year continues to apply."	
* * *	

15. Under the "Vision Benefits" section, "Calendar Year Maximums" subsection, the first sentence is revised as follows:

"**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)."

* * *

Executed this 5th day of May 2011.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 2
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on September 15, 2011, did adopt the following amendment to the Select Choice Plan in order to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This Amendment is effective January 1, 2012.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to read as follows:

"**SUMMARY OF BENEFITS**

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Mental Health & Substance Abuse		
Outpatient	80% of Contract Rate	60% of Covered Charges
Inpatient	80% of Contract Rate	60% of Covered Charges"

2. Under the "Indemnity Medical Plan" section, the "Lifetime Maximum Benefit (While Otherwise Eligible)" subsection, the second paragraph (as amended by Amendment 1) is revised to read as follows:

"**LIFETIME MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

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, per-day dollar maximums for skilled nursing, extended care, and convalescent care; per-day dollar maximums for non-PPO medical, surgical, maternity, and intermediate care; and per-day dollar maximums for non-PPO intensive care unit (ICU) services (and other calendar year visit/confinement limitations described below) are applicable."

3. Under the "Indemnity Medical Plan" section, the "Calendar Year Maximum Benefit (While Otherwise Eligible)" subsection, the second paragraph (as amended by Amendment 1) is revised to read as follows:

"**CALENDAR YEAR MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

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

* * *

4. Under the "Indemnity Medical Plan" section, "Maximum Covered Charges" subsection, Paragraph 1 entitled "Hospital/Facility Covered Charges (Inpatient)", Level 1 is revised as follows:

"**Maximum Covered Charges**

* * *

1. Hospital/Facility Covered Charges (Inpatient)

* * *

(Level 1)	Medical (including psychiatric/mental health and substance abuse), Surgical, Maternity, and Intermediate Care	$1,000 per day"

* * *

5. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies" subsection, "Medical Care" sub-subsection, Paragraph 3 is revised as follows:

"**COVERED SERVICES AND SUPPLIES**

* * *

Medical Care

* * *

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

* * *

6. Under the "Indemnity Medical Plan" section, "Limitations and Exclusions" subsection, Paragraph 7 is revised by adding the following parenthetical phrase at the end of the sentence: "(or by a physician for the treatment of any medical condition)."

7. Under the "Indemnity Medical Plan" section, "Definitions" subsection, the definition for "Hospital," item "(7)" is revised as follows:

"**DEFINITIONS**

* * *

Hospital

...(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."

* * *

8. Under the "Indemnity Medical Plan" section, "Definitions" subsection, the definition for "Skilled Nursing, Extended Care, or Convalescent Facility," item "(6)" is revised as follows:

"**DEFINITIONS**

* * *

Skilled Nursing, Extended Care, or Convalescent Facility

...(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."

* * *

Executed this 15th day of September 2011.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 3
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 9, 2012, did adopt the following amendment to the Select Choice Plan to incorporate changes made to the Health Care Tax Credit under the Trade Act of 2002 and COBRA, by provisions of the American Recovery and Reinvestment Act of 2009, the Omnibus Trade Act of 2010 and the Trade Adjustment Assistance Extension Act of 2011. The provisions of this Amendment are effective as stated herein.

1. Under the "Health Continuation Coverage Under COBRA" section, the subsection entitled "Special Tax Credit for TAA Individuals" is hereby amended to add new fifth and sixth sentences as follows:

"Health Continuation Coverage Under COBRA

* * *

SPECIAL TAX CREDIT FOR TAA INDIVIDUALS

* * *

...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 (now 72.5% of premiums for months beginning after February 12, 2011) and the COBRA coverage period through January 1, 2014."

* * *

The existing fifth sentence now becomes the seventh sentence in the paragraph.

2. Under the "Health Continuation Coverage Under COBRA" section, the subsection entitled "Special Tax Credit for TAA Individuals" the last sentence is hereby amended as follows:

"Health Continuation Coverage Under COBRA

* * *

SPECIAL TAX CREDIT FOR TAA INDIVIDUALS

* * *

...More information about the TAA Program and the extension of the tax credit and COBRA coverage period described above is available at www.doleta.gov/hctc and www.irs.gov/hctc."

Executed this 9th day of February 2012.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 4
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 18, 2012, did adopt the following amendment to the Select Choice Plan in order to comply with requirements of the Patient Protection and Affordable Care Act of 2010 for a non-grandfathered plan. This Amendment is effective September 1, 2012.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to delete the provisions related to "Physical Exams" and "Well-Baby Care" and replace them with a provision entitled "Preventive Services," as follows:

"SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Preventive Services (as specifically provided for under "Covered Services and Supplies" on pages 33-35)	100% of Contract Rate	60% of Covered Charges"
* * *		

2. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to read as follows:

"SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Emergency Room	80% of Contract Rate	80% of Covered Charges"
* * *		

3. Under the "Indemnity Medical Plan" section, the "Calendar Year Maximum Benefit (While Otherwise Eligible)" subsection, the second paragraph (as amended by Amendments 1 and 2) is revised to read as follows:

"**CALENDAR YEAR MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

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

* * *

4. Under the "Indemnity Medical Plan" section, "Amount Payable by Trust Fund," "Non-PPO Providers" subsection, the first sentence is revised as follows:

"**AMOUNT PAYABLE BY TRUST FUND**

* * *

Non-PPO Providers

Subject to the deductible, the Trust Fund will pay up to **60% 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 80% of Covered Charges); if the services incurred...

5. Under the "Indemnity Medical Plan" section, "Covered Charges," "Maximum Covered Charges" subsection, a new Paragraph 2 entitled "Emergency Room Covered Charges", is added after Paragraph 1, "Hospital/Facility Covered Charges (Inpatient)," and the existing Paragraphs 2 and 3 are renumbered Paragraphs 3 and 4, as follows:

"**COVERED CHARGES**

* * *

Maximum Covered Charges

* * *

2. Emergency Room 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."

* * *

6. Under the "Indemnity Medical Plan" section, the "Outside Geographic Area" subsection is revised as follows:

"**OUTSIDE GEOGRAPHIC AREA**

For eligible individuals residing and receiving benefits outside of the geographic area of the Trust Fund, emergency room services will be paid at 80% of Covered Charges and other covered services will be paid at 60% of the Usual, Customary, and Reasonable (UCR) Charges, as determined by the Trust Fund, subject to the deductible.

For eligible individuals traveling outside of the geographic area of the Trust Fund, emergency room services will be paid at 80% of Covered Charges and urgent care services will be paid at 60% of the Usual, Customary, and Reasonable (UCR) Charges, as determined

by the Trust Fund, subject to the deductible (no other services will be covered)."

* * *

7. Under the "Indemnity Medical Plan" section, a new subsection entitled "Health Care Provider Choices" is added after the subsection entitled "Outside Geographic Area" and before the subsection entitled "Blue Cross of California PPO Provider Network," as follows:

"**HEALTH CARE PROVIDER CHOICES**

The Trust 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 or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology (i.e., an OB-GYN)."

* * *

8. Under the "Indemnity Medical Plan" section, the "Blue Cross of California Pre-Admission Authorization/Utilization Review" subsection, the fourth paragraph in "How to Use Pre-Admission Authorization" is revised as follows:

"**BLUE CROSS OF CALIFORNIA PRE-ADMISSION AUTHORIZATION/UTILIZATION REVIEW**

* * *

How to Use Pre-Admission Authorization

* * *

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...."

9. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies," "Hospital Care" subsection, a new Paragraph 4 is added after Paragraph 3, and the existing Paragraphs 4, 5, and 6, are renumbered Paragraphs 5, 6, and 7, as follows:

"**COVERED SERVICES AND SUPPLIES**

* * *

Hospital Care

* * *

4. Emergency room services provided in an emergency department of a Hospital."

* * *

10. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies," a new subsection entitled "Preventive Services" is added after the subsection entitled "Diagnostic Laboratory and X-Ray Care" as follows:

"**COVERED SERVICES AND SUPPLIES**

* * *

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."

Executed this 18th day of October 2012.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 5
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 28, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the requirements of the Patient Protection and Affordable Care Act of 2010 for a non-grandfathered plan. This Amendment is effective September 1, 2012.

Under the "Select Choice Plan," the BENEFIT CLAIMS AND APPEAL PROCEDURES section is deleted in its entirety and replaced with the following:

"BENEFIT CLAIMS 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 authorization through Blue Cross prior to any admission (see pages 32 to 33). 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.

BENEFIT COVERAGE

The Indemnity Medical Plan also does not require pre-approval of claims for benefit coverage before medical care is received for either urgent or non-urgent claims (e.g., whether a certain benefit is a covered benefit). 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 benefit coverage issues, you may request, in writing, a Plan determination by sending your request to the Southern California Lumber Industry Welfare Fund, 13191 Crossroads Parkway North, Suite 205, City of Industry, CA 91746-3434. The Administrative Office 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). 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:

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

2. Complete the claim form for each claim.

3. Attach itemized bills and forward to:

Southern California Lumber Industry Welfare Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, CA, 91746-3434

For claims assistance, write the Administrative Office or call (562) 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.

Most hospitals and physicians' 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 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. 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 or the Trustees. 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.

PRE-SERVICE AND CONCURRENT CLAIMS

Please see the procedures 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 Decision/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 of 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 to you 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 counties.

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.

Standard/Expedited Review Processes

PRE-SERVICE AND CONCURRENT CLAIMS

Please see the procedures under PRE-SERVICE CLAIMS above for instructions 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) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational, and review of 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 Claim and Appeal Procedures

The claim and appeal rights described herein cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals, external reviews, 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)."

* * *

Executed this 28th day of February 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 5
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 28, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the requirements of the Patient Protection and Affordable Care Act of 2010 for a non-grandfathered plan. This Amendment is effective September 1, 2012.

Under the "Select Choice Plan," the BENEFIT CLAIMS AND APPEAL PROCEDURES section is deleted in its entirety and replaced with the following:

"BENEFIT CLAIMS 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 authorization through Blue Cross prior to any admission (see pages 32 to 33). 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.

BENEFIT COVERAGE

The Indemnity Medical Plan also does not require pre-approval of claims for benefit coverage before medical care is received for either urgent or non-urgent claims (e.g., whether a certain benefit is a covered benefit). 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 benefit coverage issues, you may request, in writing, a Plan determination by sending your request to the Southern California Lumber Industry Welfare Fund, 13191 Crossroads Parkway North, Suite 205, City of Industry, CA 91746-3434. The Administrative Office 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). 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:

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

2. Complete the claim form for each claim.

3. Attach itemized bills and forward to:

Southern California Lumber Industry Welfare Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, CA, 91746-3434

For claims assistance, write the Administrative Office or call (562) 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.

Most hospitals and physicians' 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 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. 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 or the Trustees. 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.

PRE-SERVICE AND CONCURRENT CLAIMS

Please see the procedures 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 Decision/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 of 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 to you 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 counties.

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.

Standard/Expedited Review Processes

PRE-SERVICE AND CONCURRENT CLAIMS

Please see the procedures under PRE-SERVICE CLAIMS above for instructions 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) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational, and review of 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 Claim and Appeal Procedures

The claim and appeal rights described herein cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals, external reviews, 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)."

* * *

Executed this 28th day of February 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 6
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 28, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the requirements of the Patient Protection and Affordable Care Act of 2010 for a non-grandfathered plan. This Amendment is effective September 1, 2012.

Under the "Eligibility" section, "Definition of Eligible Dependents" subsection (as amended by Amendment No. 1 to the Plan), Item 3 is revised as follows:

"Eligibility

* * *

Definition of Eligible Dependents

* * *

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

* * *

Executed this 28th day of February 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 7
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 28, 2013, did adopt the following amendment to the Select Choice Plan in order to clarify the Hospice Care Benefit under the Plan. This Amendment is effective January 1, 2013.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to read as follows:

"SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Home Health Care		
Hospice Care	80% of Contract Rate, (maximum lifetime limit - $20,000)	80% of Covered Charges, (maximum lifetime limit - $20,000)"

* * *

2. Under the "Indemnity Medical Plan" section, the "Lifetime Maximum Benefit (While Otherwise Eligible)" subsection, Paragraph 2 (as amended by Amendments No. 1 and No. 2 to the Plan), is revised as follows:

"**LIFETIME MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

Certain maximums, such as lifetime (or annual) dollar value limits on non-essential health benefits;...still apply to specific periods, conditions, or types or levels of care. For example, the per lifetime maximum for Hospice Care of $20,000;..."

* * *

3. Under the "Indemnity Medical Plan" section, the "Covered Services and Supplies" subsection, a new Hospice Care description is added after the "Home Health Care" subsection as follows:

"COVERED SERVICES AND SUPPLIES

* * *

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."

* * *

4. Under the "Indemnity Medical Plan" section, the "Definitions" subsection, a new "Hospice Care" definition is added after the "Skilled Nursing, Extended Care or Convalescent Facility" definition as follows:

"**DEFINITIONS**

* * *

Hospice care: means 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."

* * *

Executed this 28th day of February 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 8
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 28, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the requirements of the Patient Protection and Affordable Care Act of 2010 for a non-grandfathered plan. This Amendment is effective September 1, 2012.

Under the "Select Choice Plan," the "INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES" section is deleted in its entirety and replaced with the following:

"INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL 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

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 one area: Specialty Drugs.

Prescription Solutions/Optum Rx, the Fund's current pharmacy benefit manager, will determine for the Plan whether a claimant's Specialty Drug claim 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 for Specialty Drugs

An urgent care claim for Specialty Drugs 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 Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx at 1 (800) 797-9791, if made orally.

Written requests should be addressed to Prescription Solutions/Optum Rx at:

RxSOLUTIONS/OPTUM Rx, INC.
d/b/a Prescription Solutions
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. Prescription Solutions/Optum Rx will notify you of its decision within 72 hours of receipt of the claim. You and Prescription Solutions/Optum Rx may agree to an extension of this time period, but Prescription Solutions/Optum Rx may not unilaterally extend same. Notification may be oral, unless written notification is requested by you or your authorized representative. Any oral notification by Prescription Solutions/Optum Rx 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, Prescription Solutions/Optum Rx 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 is filed with Prescription Solutions/Optum Rx, 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 Prescription Solutions/Optum Rx may agree to further extensions of these time periods.

Non-Urgent Care Claims for Specialty Drugs

A non-urgent claim for Specialty Drugs 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 Prescription Solutions/Optum Rx at:

RxSOLUTIONS/OPTUM Rx, INC.
d/b/a Prescription Solutions
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, Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx expects to render a decision. You and Prescription Solutions/Optum Rx 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, Prescription Solutions/Optum Rx will notify you as soon as possible but no later than the end of the initial 15-day period of what is required to file a complete claim. You will have at least 45 days from the receipt of the notice within which to provide the information. You and Prescription Solutions/Optum Rx 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

A concurrent care claim for Specialty Drugs is a claim for continued use of the Specialty 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 Prescriptions Solutions/Optum Rx of any reduction or termination of a previously approved Specialty 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 Prescription Solutions/Optum Rx 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 126.)

BENEFIT COVERAGE

The Indemnity Prescription Drug Plan does not require pre-approval of claims for benefit coverage before other Prescription Drugs are purchased for either urgent or non-urgent pre-service or concurrent care claims (e.g., whether a certain benefit is a covered benefit). Therefore, the Department of Labor ("DOL") Benefit Claims and Appeal Procedures 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 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 benefit coverage issues before you purchase a Prescription Drug, you may request, in writing, a Plan determination by sending your request to:

Southern California Lumber Industry Welfare Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, CA 91746-3434

The Administrative Office 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 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 (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 Specialty Drug claims. Prescription Solutions/Optum Rx handles post-service claims. If you file a post-service claim, Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx:

(1) Obtain a claim form from the Administrative Office;
(2) Complete Part I of the claim form;
(3) Complete Part II (and attach an itemized billing); and
(4) Provide the form along with the itemized billing to Prescription Solutions/Optum Rx at:

Prescription Solutions/Optum Rx
P.O. Box 29044
Hot Springs, AR 71903

For claims assistance, write Prescription Solutions/Optum Rx 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.

Prescription Solutions/Optum Rx will notify you of its decision within 30 days of receipt of the claim. Prescription Solutions/Optum Rx is allowed one 15-day maximum extension if the claim decision cannot be made for reasons beyond the control of Prescription Solutions/Optum Rx and Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx 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, Prescription Solutions/Optum Rx will notify you within 30 days of the failure and inform you of 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 Prescription Solutions/Optum Rx 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 on which 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 Prescription Solutions/Optum Rx'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 claimant 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 a 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 Prescription Solutions/Optum Rx, 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. 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 Prescription Solutions/Optum Rx 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.

PRE-SERVICE CLAIMS FOR SPECIALTY DRUGS

Claimant may file a request for an appeal of any Prescription Solutions/Optum Rx pre-service claim decision on Specialty Drugs. 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 Prescription Solutions/Optum Rx.

Appeal Procedures for Pre-Service Urgent Care Claims

Claimant may file a request for an expedited urgent care appeal to Prescription Solutions/Optum Rx either orally at 800-797-9791 or in writing by you, your physician or authorized representative to Prescription Solutions/Optum Rx at:

RxSOLUTIONS/OPTUM Rx, INC.
d/b/a Prescription Solutions
2300 Main Street
Irvine, California 92614

Information transmitted between Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx at:

RxSOLUTIONS/OPTUM Rx, INC.
d/b/a Prescription Solutions
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

Claimant may file a request for an appeal of any Prescription Solutions/Optum Rx concurrent care claim decision on Specialty Drugs. Concurrent care claims denials are subject to one level of mandatory appeal to Prescription Solutions/Optum Rx.

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 129-130.

BENEFIT COVERAGE

There are no appeals of pre-service or concurrent care 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 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
13191 Crossroads Parkway North, Suite 205
City of Industry, CA 91746-3434

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 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 claim 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, Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx 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 and copies of all documents, records and other information relevant to the Claimant's claim for benefits;

6. A description of Prescription Solutions/Optum Rx'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. An explanation of the External Appeal Procedures 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, if applicable, 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, for questions about your rights, the final 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

Prescription Solutions/Optum Rx'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 review process.

Prescription Solutions/Optum Rx 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.

Prescription Solutions/Optum Rx or the Trustees, as applicable, will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of Prescription Solutions/Optum Rx or the Trustees, as applicable, in connection with the claim under appeal.

Any entity reviewing Prescription Solutions/Optum Rx's or the Trustees' decision, as applicable, may not consider evidence or facts that were not presented to Prescription Solutions/Optum Rx or the Trustees on appeal. Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx or the Trustees, as applicable, 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 Prescription Solutions/Optum Rx or the Trustees, as applicable, asserts the *de minimis* exception, you may request a written explanation of the violation from Prescription Solutions/Optum Rx or the Trustees, as applicable, and Prescription Solutions/Optum Rx or the Trustees, as applicable, must provide

such explanation within 10 days, including a specific description of their basis, if any, for asserting that that the violation should not cause the Internal Appeal Procedures to be deemed exhausted.

Standard Review Process

If your Prescription Drug claim (pre-service, concurrent, or post-service) is denied by Prescription Solutions/Optum Rx 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). Prescription Solutions/Optum Rx 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) based on medical necessity, appropriateness, or effectiveness of a covered Prescription Drug; or a determination that a Prescription Drug is experimental or investigational, and review of any decision to rescind coverage.

You will be notified within one day after Prescription Solutions/Optum Rx 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, Prescription Solutions/Optum Rx or the Administrative Office, as applicable, will refer the claim to an IRO. Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx 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 Specialty Drug claim) is denied by Prescription Solutions/Optum Rx, a Claimant may make a request for an expedited external review with Prescription Solutions/Optum Rx 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 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, Prescription Solutions/Optum Rx must determine whether the request meets the reviewability requirements set forth under the Standard External Review Procedures (see above). Prescription Solutions/Optum Rx 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, Prescription Solutions/Optum Rx will assign an IRO pursuant to the requirements set forth in the Standard External Review Procedures (see above). Prescription Solutions/Optum Rx 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 Prescription Solutions/Optum Rx.

Miscellaneous Benefit Claim and Appeal Procedures

The claim and appeal rights described herein 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 Prescription Solutions/Optum Rx 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)."

* * *

Executed this 28th day of February 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 9
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 29, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act") and the final regulations published in January 2013 implementing the HITECH Act. This Amendment is effective September 23, 2013, unless otherwise stated.

The section entitled PRIVACY AND YOUR PROTECTED HEALTH INFORMATION is deleted in its entirety and replaced with the following:

"PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

This 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, or 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's 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 the enrollment and/or continued eligibility under 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 Disclosures 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 Notice. 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. This Plan is required to comply with a restriction request if you request restricted disclosure of PHI to this 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 form requesting 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 and format requested by you if it is readily producible; or, if not, in a readable electronic form and 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. This 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 this Plan 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, this 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 this 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 and 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. This 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.

This 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 Adjustors, 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, disclosure, 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 law; or uses or disclosures that are required for 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 scope of authority 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 this 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, this 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 this 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 this 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 this 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 this Plan to have affected more than 500 individuals in a particular state or jurisdiction, this 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, this 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 this 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 making a communication about a product or service that encourages recipients of the communication to purchase or use 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 case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions.

This Plan does not anticipate making any fundraising communications; 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 this 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, 13191 Crossroads Parkway No., Suite 205, City of Industry, CA 91746-3434. A complaint may also be filed with 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."

Executed this 29th day of August 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 10
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on December 3, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the United States Supreme Court decision in *United States v. Windsor*. This Amendment is effective June 26, 2013 (unless an earlier date is mandated by law).

Under the "Eligibility" section, "Definition of Eligible Dependents" subsection, the definition of "Spouse" is revised as follows:

"ELIGIBILITY

* * *

DEFINITION OF ELIGIBLE DEPENDENTS

* * *

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."

Executed this 3rd day of December 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 11
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on December 3, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with requirements of the Patient Protection and Affordable Care Act of 2010 for non-grandfathered plans. This Amendment is effective January 1, 2014.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" subsection is revised to add a new section after the "Deductible" section and before the "Plan Pays" designation as follows:

"SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		

Out-of-Pocket Maximum	$6,350 per person/$12,700 per family in 2014 (to be increased in 2015 and later as permitted under section 1302(c)(1) of the Patient Protection and Affordable Care Act of 2010)	None"
* * *		

2. Under the "Indemnity Medical Plan" section, a new subsection is added after the "Deductible" subsection and before the "Amount Payable By Trust Fund" subsection as follows:

* * *

"**OUT-OF-POCKET MAXIMUM**

There is an out-of-pocket maximum of $6,350/person and $12,700/family in 2014 (to be increased in 2015 and later 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. There is no out-of-pocket maximum if you use a Non-PPO provider."

* * *

3. Under the "Indemnity Medical Plan" section, "Amount Payable By Trust Fund," "Blue Cross PPO Providers" subsection, the first and fourth sentences are revised as follows:

"**AMOUNT PAYABLE BY TRUST 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). ...You will be responsible for the remaining 20% (up to the out-of-pocket maximum). ..."

* * *

4. Under the "Indemnity Medical Plan" section, the "Blue Cross of California PPO Provider Network" subsection is revised as follows:

"BLUE CROSS OF CALIFORNIA PPO PROVIDER NETWORK

...Therefore, if you use a Blue Cross PPO provider and/or hospital, your out-of-pocket costs can be reduced substantially.

YOUR LOWEST COST WILL BE FROM A BLUE CROSS PPO PROVIDER

* * *

By using a Blue Cross Provider, you save money in the following 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."

5. Under the "Indemnity Medical Plan" section, "Limitations and Exclusions" subsection, Paragraph 26 is revised as follows:

"LIMITATIONS AND EXCLUSIONS

* * *

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

* * *

6. Under the "Indemnity Medical Plan" section, "Limitations and Exclusions" subsection, Paragraph 28 is revised to add a parenthetical statement at the end as follows:

"**LIMITATIONS AND EXCLUSIONS**

* * *

28. ...(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)."

* * *

7. Under the "Indemnity Medical Plan" section, "Definitions" subsection, the definition for "Physician" is revised as follows:

"**DEFINITIONS**

* * *

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...Psychologist; or when performing services upon referral, by a licensed or certified...list of such nurses; or other service providers practicing within the scope of their licenses or certifications, as applicable and to the extent that benefits are provided."

* * *

Executed this 3rd day of December 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 12
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on December 3, 2013, did adopt the following amendment to the Select Choice Plan in order to comply with the 90-day waiting period limitation rules under the Patient Protection and Affordable Care Act of 2010. This Amendment is effective January 1, 2014.

Under the "Eligibility" section, the "Initial Eligibility," "Active Employees" subsection is revised to delete the second sentence (which is in parenthesis) allowing a probationary period of up to 90 days if specified in the applicable Collective Bargaining Agreement.

Executed this 3rd day of December 2013.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 13
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 27, 2014, did adopt the following amendment to the Select Choice Plan in order to clarify plan changes required under the Patient Protection and Affordable Care Act of 2010 for non-grandfathered plans. This Amendment is effective September 1, 2012.

1. Under the "Prescription Drug Benefits" section, the "Summary of Benefits" chart is revised to add a note at the bottom of the chart as follows:

"**PRESCRIPTION DRUG BENEFITS**

* * *

SUMMARY OF BENEFITS

TYPE OF PRESCRIPTION	**TYPE OF DRUG**	**COPAYMENT**
* * *	* * *	* * *
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)."		

2. Under the "Prescription Drug Benefits" section, "Covered Drugs and Supplies" subsection, a new paragraph number 16 is added at the end as follows:

"**PRESCRIPTION DRUG BENEFITS**

* * *

COVERED DRUGS AND SUPPLIES

* * *

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."

3. Under the "Prescription Drug Benefits" section, "Limitations and Exclusions" subsection, the first sentence is revised to include the parenthetical phrase "(except as otherwise covered above)" at the end of the sentence (before the colon).

Executed this 27th day of February 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 14
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on December 3, 2013, did adopt the following amendment to the Select Choice Plan in order to add a special eligibility rule for new employers. This Amendment is effective January 1, 2014.

1. Under the "Eligibility" section, "Initial Eligibility," "Active Employees" subsection, a new section is added at the end of the subsection and before the "Dependents" subsection, as follows:

"**ELIGIBILITY**

Initial Eligibility

ACTIVE EMPLOYEES

* * *

*** 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."

2. Under the "Eligibility" section, "When Your Eligibility Terminates" subsection, the second paragraph is revised, as follows:

"**ELIGIBILITY**

* * *

When Your Eligibility Terminates

* * *

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."

Executed this 27th day of February 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 15
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 14, 2014, did adopt the following amendment to the Select Choice Plan in order to establish the period of time within which a Claimant must file an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This Amendment is effective August 14, 2014.

Under the "Select Choice Plan," the "BENEFIT CLAIMS AND APPEAL PROCEDURES," the "Miscellaneous Benefit Claim and Appeal Procedures" subsection (as previously amended by Amendment No. 5) is revised to add a third paragraph as follows:

"**BENEFIT CLAIMS AND APPEAL PROCEDURES**

* * *

Miscellaneous Benefit Claim and Appeal Procedures

* * *

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."

Executed this 14th day of August 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 16
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 14, 2014, did adopt the following amendment to the Select Choice Plan in order to establish the period of time within which a Claimant must file an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This Amendment is effective August 14, 2014.

1. Under the "Select Choice Plan," the "INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES," the "Miscellaneous Benefit Claim and Appeal Procedures" subsection (as previously amended by Amendment No. 8) is revised to add a third paragraph as follows:

"INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

Miscellaneous Benefit Claim and Appeal Procedures

* * *

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."

Executed this 14th day of August 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 17
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 14, 2014, did adopt the following amendment to the Select Choice Plan in order to add a rule regarding reinstatement of eligibility upon an employee's rehire. This Amendment is effective immediately.

1. Under the "Eligibility" section, a new subsection entitled "Reinstatement of Eligibility" is added after the "When Your Eligibility Terminates" subsection as follows:

"**ELIGIBILITY**

* * *

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.)"

Executed this 14th day of August 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 18
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 9, 2014, did adopt the following amendment to the Select Choice Plan in order to comply with requirements of the Patient Protection and Affordable Care Act of 2010 regarding out-of-pocket maximums. This Amendment is effective January 1, 2015.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" chart, "Out-of-Pocket Maximum" section (as added by Amendment No. 11) is revised as follows:

"INDEMNITY MEDICAL PLAN

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		

Out-of-Pocket Maximum	2014	$6,350/person $12,700/family	None"
	2015	$6,600/person* $13,200/family*	
	* Combined with prescription drug out-of-pocket costs (e.g., copayments) for prescription drugs covered under the indemnity prescription drug program. * To be increased in 2016 and later as permitted under section 1302(c)(1) of the Patient Protection and Affordable Care Act of 2010.		
* * *			

2. Under the "Indemnity Medical Plan" section, the "Out-of-Pocket Maximum" subsection (as added by Amendment No. 11) is revised as follows:

"INDEMNITY MEDICAL PLAN

* * *

OUT-OF-POCKET MAXIMUM

There is an out-of-pocket maximum of $6,350/person and $12,700/family in 2014, and $6,600/person and $13,200/family in 2015 (to be increased in 2016 and later 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. There is no out-of-pocket maximum if you use a Non-PPO provider."

* * *

3. Under the "Prescription Drug Benefit" section, a new subsection is added after the "Summary of Benefits" subsection and before the "Covered Prescriptions" subsection as follows:

"PRESCRIPTION DRUG BENEFITS

* * *

OUT-OF-POCKET MAXIMUM

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 in 2015 (to be increased in 2016 and later 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 pages [redacted] of this Plan Booklet for more information."

Executed this 9th day of October 2014.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 19
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 9, 2014, did adopt the following amendment to the Select Choice Plan to improve the Skilled Nursing, Extended Care, and Convalescent Facility benefits. This Amendment is effective January 1, 2015.

1. Under the "Indemnity Medical Plan" section, "Summary of Benefits" chart, the "Skilled Nursing, Extended Care & Convalescent Care" benefits section is revised as follows:

"INDEMNITY MEDICAL PLAN

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Skilled Nursing, Extended Care, and Convalescent Facility Care	80% of Contract Rate (60-day maximum per Benefit Period)	60% of Covered Changes (60-day maximum per Benefit Period)"
* * *		

2. Under the "Indemnity Medical Plan" section, "Lifetime Maximum Benefit (While Otherwise Eligible)" subsection, the second paragraph (as amended by Amendment Nos. 1, 2, and 7) is revised as follows:

"**LIFETIME MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

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-lifetime maximum for Hospice Care of $20,000; 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."

3. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies," "Hospital Care" subsection (as amended by Amendment No. 4), Paragraph 6 is revised as follows:

"**COVERED SERVICES AND SUPPLIES**

* * *

Hospital Care
Covered services are:

* * *

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."

* * *

4. Under the "Indemnity Medical Plan" section, the "Definitions" subsection, a new term is added before "Contract Rate" entitled "Benefit Period" to read as follows:

"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."

* * *

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 20
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 26, 2015, did adopt the following amendment to the Select Choice Plan to clarify Residential Treatment Facility benefits under the Indemnity Medical Plan in compliance with the final regulations under the Mental Health Parity and Addiction Equity Act. This Amendment is effective January 1, 2015.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" chart, "Mental Health & Substance Abuse" benefits section (as revised by Amendments Nos. 1 and 2) is revised as follows:

"**INDEMNITY MEDICAL PLAN**

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Mental Health & Substance Use Disorders Outpatient	80% of Contract Rate	60% of Covered Charges
Inpatient (including Residential Treatment Facilities)	80% of Contract Rate	60% of Covered Charges Maximum Covered Charges of $1,000/day"

* * *

2. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies" subsection, a new section is added after "Medical Care" and before "Diagnostic Laboratory and X-Ray Care" entitled "Residential Treatment Facility Care" to read as follows:

"**COVERED SERVICES AND SUPPLIES**

* * *

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."

3. Under the "Indemnity Medical Plan" section, the "Definitions" subsection, a new term is added after "Psychiatric Mental Health Nursing Service" and before "Skilled Nursing, Extended Care, or Convalescent Facility" entitled "Residential Treatment Facility" to read as follows:

* * *

"**Residential Treatment Facility:** a psychiatric 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 physicians on the premises; and

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

* * *

4. Under the "Indemnity Medical Plan" section, any references to "substance abuse" are changed to "substance use disorder."

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 21
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 26, 2015, did adopt the following amendment to the Select Choice Plan in order to comply with requirements of the Patient Protection and Affordable Care Act of 2010 regarding pediatric dental and vision out-of-pocket maximums. This Amendment is effective January 1, 2015.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" chart, "Out-of-Pocket Maximum" section (as added by Amendment No. 11 and revised by Amendment No. 18) is revised to add two new (*) paragraphs between the existing (*) paragraphs as follows:

"INDEMNITY MEDICAL PLAN

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		

Out-of-Pocket Maximum	* * * * 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). * * *	None"
* * *		

2. Under the "Indemnity Medical Plan" section, the "Out-of-Pocket Maximum" subsection (as added by Amendment No. 11 and revised by Amendment No. 18) is revised to add a new third sentence as follows:

"**INDEMNITY MEDICAL PLAN**

* * *

OUT-OF-POCKET MAXIMUM

There is an out-of-pocket maximum of $6,350/person and $12,700/family in 2014, and $6,600/person and $13,200/family in 2015 (to be increased in 2016 and later 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."

* * *

3. Under the "Scheduled Dental Plan" section, the "Summary of Dental Benefits" chart (as revised by Amendment No. 1) is revised to add a new section after the "Deductible" section entitled "Out-of-Pocket Maximum" as follows:

"**SUMMARY OF DENTAL BENEFITS**

BENEFITS	**SCHEDULED DENTAL PLAN COVERAGES**
* * *	* * *
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*"
* * *	

4. Under the "Vision Benefits" section, the "Summary of Benefits" chart (as revised by Amendment No. 1) is revised to add a new (*) paragraph at the bottom of the chart as follows:

"**SUMMARY OF BENEFITS**

BENEFIT	**PLAN PAYS**
* * *	
* * * *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)."	
* * *	

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 22
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 26, 2015, did adopt the following amendment to the Select Choice Plan to add an additional reference to the period of time within which a Claimant must file an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This Amendment is effective February 26, 2015.

1. Under the "Select Choice Plan," the "INDEMNITY MEDICAL PLAN" section, a new subsection is added at the end of the section, following the "PAYMENT OF CLAIMS" subsection, as follows:

"INDEMNITY MEDICAL PLAN

* * *

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 CLAIMS AND APPEAL PROCEDURES for the detailed Benefit Claim and Appeal Procedures (pages 113 to 116 as amended by Amendments Nos. 5 and 15)."

2. Under the "Select Choice Plan," the "BENEFIT CLAIM AND APPEAL PROCEDURES," the "MISCELLANEOUS BENEFIT CLAIM AND APPEAL PROCEDURES" subsection (as previously amended by Amendment No. 15) is revised by adding above the third paragraph the heading "**Time Limitation for a Section 502(a) Lawsuit**."

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 23
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 26, 2015, did adopt the following amendment to the Select Choice Plan to add an additional reference to the period of time within which a Claimant must file an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This Amendment is effective February 26, 2015.

1. Under the "Select Choice Plan," the "PRESCRIPTION DRUG BENEFITS" section, a new subsection is added at the end of the section, following the "LIMITATIONS AND EXCLUSIONS" subsection, as follows:

"PRESCRIPTION DRUG BENEFITS

* * *

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 APPEAL PROCEDURES for the detailed Indemnity Prescription Drug Benefit Claim and Appeal Procedures (pages 117 to 124 as amended by Amendments Nos. 8 and 16)."

2. Under the "Select Choice Plan," the "INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIM AND APPEAL PROCEDURES," the "Miscellaneous Benefit Claim and Appeal Procedures" subsection (as previously amended by Amendment No. 16) is revised by adding above the third paragraph the heading "**Time Limitation for a Section 502(a) Lawsuit**."

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 24
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 26, 2015, did adopt the following amendment to the Select Choice Plan to eliminate the language related to Creditable Coverage Certificates under HIPAA in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Final Regulations issued by the DOL, HHS, and the IRS on the PPACA 90-Day Waiting Period Limitation. The requirement to provide such certificates is superseded by the prohibition on preexisting condition exclusions. This Amendment is effective January 1, 2015.

The section entitled "CERTIFICATION OF CREDITABLE COVERAGE UNDER HIPAA" is deleted in its entirety.

Executed this 26th day of February 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 25
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 22, 2015, did adopt the following amendment to the Select Choice Plan in order to clarify the Plan's out-of-pocket rules in light of the Trustees' decision at a meeting on August 13, 2015, not to increase the out-of-pocket maximum for 2016. This Amendment is effective immediately.

1. Under the "Indemnity Medical Plan" section, the "Summary of Benefits" chart, "Out-of-Pocket Maximum" section (as added by Amendment No. 11 and revised by Amendments No. 18 and No. 21), including the fourth (*) paragraph, is revised as follows:

"INDEMNITY MEDICAL PLAN

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		

Out-of-Pocket Maximum	* * * 2015** $6,600/person* $13,200/family* * * * ** The out-of-pocket maximum may be increased in 2016 or later, at the Trustees' discretion, as permitted under section 1302(c)(1) of the Patient Protection and Affordable Care Act of 2010. Any approved increases will be implemented through future Plan Amendments.	None"
* * *		

2. Under the "Indemnity Medical Plan" section, the "Out-of-Pocket Maximum" subsection (as added by Amendment No. 11 and revised by Amendments No. 18 and No. 21) is revised as follows:

"**INDEMNITY MEDICAL PLAN**

* * *

OUT-OF-POCKET MAXIMUM

There is an out-of-pocket maximum of $6,350/person and $12,700/family effective for 2014, and $6,600/person and $13,200/family starting in 2015, if you use a Blue Cross PPO provider. (The out-of-pocket maximum may be increased in 2016 or later, at the Trustees' discretion, as permitted under section 1302(c)(1) of the Patient Protection and Affordable Care Act of 2010. Any approved increases will be implemented through future Plan Amendments.)..."

* * *

3. Under the "Prescription Drug Benefit" section, the "Out-of-Pocket Maximum" subsection (as added by Amendment No. 18) is revised as follows:

"**PRESCRIPTION DRUG BENEFITS**

* * *

OUT-OF-POCKET MAXIMUM

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 starting in 2015. (The out-of-pocket maximum may be increased in 2016 or later, at the Trustees' discretion, as permitted under section 1302(c)(1) of the Patient Protection and Affordable Care Act of 2010. Any approved increases will be implemented through future Plan Amendments.)..."

* * *

Executed this 22nd day of October 2015.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 26
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 24, 2016, did adopt the following amendment to the Select Choice Plan in order to clarify coverage of recommended preventive services under the Patient Protection and Affordable Care Act of 2010, and the regulations promulgated thereunder. This Amendment is effective immediately.

1. Under the "Indemnity Medical Plan" section, "Covered Services and Supplies," "Pregnancy" subsection, the second sentence of the first paragraph is revised as follows:

"INDEMNITY MEDICAL PLAN

* * *

COVERED SERVICES AND SUPPLIES

* * *

Pregnancy

...Pregnancy benefits for dependent children are limited to complications of pregnancy only (except as otherwise covered under Preventive Services). ..."

* * *

2. Under the "Indemnity Medical Plan" section, "Limitations and Exclusions" subsection, paragraph no. 16 is revised as follows:

* * *

"INDEMNITY MEDICAL PLAN

* * *

LIMITATIONS AND EXCLUSIONS

* * *

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

* * *

Executed this 24th day of February 2016.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 27
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on February 24, 2016, did adopt the following amendment to the Select Choice Plan to address the Plan's reimbursement rights with respect to recovery of unauthorized or mistaken benefit payments made in connection with third party liability claims (including workers' compensation claims, etc.). This Amendment is effective immediately.

Under the "Information About the Administration of the Plan" section, the "11. Circumstances Which May Result in Disqualification, Ineligibility, or Denial, Loss, Forfeiture, Suspension, Offset, Reduction, or Recovery of Benefits" subsection, item "f" in the second paragraph (on page 131) is revised as follows:

"INFORMATION ABOUT THE ADMINISTRATION OF THE PLAN

* * *

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 may nonetheless be denied benefits as a result of one or more of the following circumstances:

* * *

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."

* * *

Executed this 24th day of February 2016.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 28
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 11, 2016, did adopt the following amendment to the Select Choice Plan in order to revise the Benefit Claims and Appeal Procedures in compliance with the requirements of the Patient Protection and Affordable Care Act of 2010, and the regulations promulgated thereunder. This Amendment is effective January 1, 2017.

1. Under the "Benefit Claims and Appeal Procedures" section, the "Internal Appeal Procedures" subsection (as previously amended by Amendment No. 5) is revised to add a new sixth sentence to the end of the first paragraph as follows:

"**BENEFIT CLAIMS AND APPEAL PROCEDURES**

* * *

Internal Appeal Procedures

... If the new or additional evidence 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."

* * *

2. Under the "Benefit Claims and Appeal Procedures" section, "Standard/Expedited Review Processes" subsection (as previously amended by Amendment No. 5), the subsection heading is revised to "External Review Process" and the last sentence of the first paragraph in the "Post-Service Claims" subsection is revised as follows:

"**BENEFIT CLAIMS AND APPEAL PROCEDURES**

* * *

External Review Process

* * *

POST-SERVICE CLAIMS

...Claims that are eligible for external review involve 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."

* * *

3. Under the "Indemnity Prescription Drug Benefit Claims and Appeal Procedures" section, the "Internal Appeal Procedures" subsection (as previously amended by Amendment No. 8) is revised to add a new sixth sentence to the end of the first paragraph as follows:

"INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

Internal Appeal Procedures

... 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."

* * *

4. Under the "Indemnity Prescription Drug Benefit Claims and Appeal Procedures" section, "Standard Review Process" subsection (as previously amended by Amendment No. 8), a new heading entitled "External Review Process" is added before the "Standard Review Process" subsection, the "Standard Review Process" subsection heading is revised to "Standard External Review Process," and the last sentence of the first paragraph in the "Standard External Review Process" subsection is revised as follows:

"INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

External Review Process

STANDARD EXTERNAL REVIEW PROCESS

...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 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."

* * *

Executed this 11th day of August 2016.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 29
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on August 11, 2016, did adopt the following amendment to the Select Choice Plan in order to clarify the definitions of "Emergency" and "Emergency Services" in compliance with the requirements of the Patient Protection and Affordable Care Act of 2010, and the regulations promulgated thereunder. This Amendment is effective September 1, 2012.

1. Under the "Indemnity Medical Plan" section, all references to "emergency room" or "emergency room services" (including references added by Amendment No. 4) are revised to "Emergency Services."

2. Under the "Indemnity Medical Plan" section, "Definitions" subsection, new definitions for "Emergency" and "Emergency Services" are added after the definition of "Deductible" as follows:

"INDEMNITY MEDICAL PLAN

* * *

DEFINITIONS

* * *

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."

* * *

Executed this 11th day of August 2016.

Chairman Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 30
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 20, 2016, did adopt the following Amendment to the Select Choice Plan in order to eliminate the Hospice Care benefit limitation in compliance with the rules regarding essential health benefits under the Patient Protection and Affordable Care Act. This Amendment is effective January 1, 2017.

1. Under the "Indemnity Medical Plan" section, "Summary of Benefits" chart, the "Hospice Care" section (as amended by Amendment No. 7) is revised as follows:

"**INDEMNITY MEDICAL PLAN**

* * *

SUMMARY OF BENEFITS

BENEFITS	**INDEMNITY MEDICAL PLAN COVERAGES**	
* * *		
	Blue Cross PPO Provider	**Non-PPO Provider**
* * *		
Hospice Care	80% of Contract Rate	60% of Covered Charges"
* * *		

2. Under the "Indemnity Medical Plan" section, "Lifetime Maximum Benefit (While Otherwise Eligible)" subsection, the second paragraph (as amended by Amendment Nos. 1, 2, 7, and 19) is revised to delete the reference to Hospice Care as follows:

"**LIFETIME MAXIMUM BENEFIT (WHILE OTHERWISE ELIGIBLE)**

* * *

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."

* * *

Executed this 20th day of October 2016.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 31
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on May 4, 2017, did adopt the following Amendment to the Select Choice Plan Indemnity Prescription Drug Benefits in order to implement the Compound Medication Management Program approved at the February 23, 2017 Board of Trustees meeting. This Amendment is effective August 1, 2017.

1. Under the "Prescription Drug Benefits" section, a new subsection entitled "Compound Medication Management Program" is added following the "Specialty Drugs" subsection and before the "Covered Drugs and Supplies" subsection as follows:

"PRESCRIPTION DRUG BENEFITS

* * *

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 to 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."

* * *

2. Under the "Prescription Drug Benefits" section, "Limitations and Exclusions" subsection, a new Item No. 38 is added at the end of the section as follows:

"PRESCRIPTION DRUG BENEFITS

* * *

LIMITATIONS AND EXCLUSIONS

* * *

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

* * *

3. Under the "Indemnity Prescription Drug Benefit Claims and Appeals Procedures" section, all references to preauthorization for Specialty Drugs, and to the claims and appeal procedures related to Specialty Drugs, are revised to refer to both "Specialty Drugs" and "compound drugs that cost $50 or more."

* * *

Executed this 4th day of May 2017.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 32
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on May 4, 2017, did adopt the following Amendment to the Select Choice Plan in order to further explain how a disability is verified for purposes of the eligibility rules extending coverage beyond age 26 for disabled/handicapped dependent children.

Under the "Eligibility" section, "Definition of Eligible Dependents," "Dependent Children" subsection (as amended by Amendment No. 1 to the Plan) the second sentence in the third paragraph is revised as follows:

"**ELIGIBILITY**

* * *

DEFINITION OF ELIGIBLE DEPENDENTS

* * *

Dependent Children

* * *

... 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...."

* * *

Executed this 4th day of May 2017.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 33
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on May 9, 2018, did adopt the following Amendment to the Select Choice Plan to prohibit class action lawsuits in benefit claim matters. This Amendment is effective May 9, 2018.

1. Under the "Benefit Claims and Appeal Procedures" section, the "Miscellaneous Benefit Claims and Appeal Procedures" subsection (as previously amended by Amendments No. 5, 15, and 22) is revised by adding three new sentences to the end of the first paragraph as follows:

"BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

Miscellaneous Benefit Claim and Appeal Procedures

...Actions brought under Section 502(a) of ERISA may only be brought by a Claimant in his/her individual capacity and not as a plaintiff or class member in any purported or proposed class or representative action of any kind. Unless the Claimant(s) to any Section 502(a) action(s) and the Fund both(all) agree, no action may be consolidated with another person's (or other persons') claim(s) or heard in any form of a representative or class proceeding. Enrollment in the Select Choice Plan thus constitutes a waiver of any specific, general, or implied right under any statute or regulation, etc., to pursue a class action lawsuit as a plaintiff/class member."

* * *

2. Under the "Indemnity Prescription Drug Benefit Claims and Appeal Procedures" section, the "Miscellaneous Benefit Claim and Appeal Procedures" subsection (as previously amended by

Amendments No. 8, 16, and 23) is revised by adding three new sentences to the end of the first paragraph as follows:

"INDEMNITY PRESCRIPTION DRUG BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

Miscellaneous Benefit Claim and Appeal Procedures

...Actions brought under Section 502(a) of ERISA may only be brought by a Claimant in his/her individual capacity and not as a plaintiff or class member in any purported or proposed class or representative action of any kind. Unless the Claimant(s) to any Section 502(a) action(s) and the Fund both(all) agree, no action may be consolidated with another person's (or other persons') claim(s) or heard in any form of a representative or class proceeding. Enrollment in the Select Choice Plan Indemnity Prescription Drug Plan thus constitutes a waiver of any specific, general, or implied right under any statute or regulation, etc., to pursue a class action lawsuit as a plaintiff/class member."

* * *

Executed this 9th day of May 2018.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 34
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on May 9, 2018, did adopt the following Amendment to the Select Choice Plan to clarify that the Plan exclusion for gastric bypass surgery and other related surgeries, which are performed for the treatment of obesity, weight reduction, or weight control, are excluded for any purpose. This Amendment is effective May 9, 2018.

Under the "Indemnity Medical Plan" section, "Limitations and Exclusions," subsection, paragraph no. 16 (as previously amended by Amendment No. 26) is revised as follows:

* * *

"**LIMITATIONS AND EXCLUSIONS**

* * *

16. Treatment for obesity, or complications from any treatment thereof, including but not limited to gastric bypass surgery or any related surgeries or services (except as otherwise covered under Preventive Services). This exclusion is not limited to those cases in which weight loss, etc., is the only purpose for the treatment and specifically applies to exclude gastric bypass surgery, etc., for any and all purposes."

* * *

Executed this 9th day of May 2018.

Chairman

Secretary

SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND
AMENDMENT NO. 35
TO THE SOUTHERN CALIFORNIA LUMBER INDUSTRY
WELFARE FUND'S SELECT CHOICE PLAN
(As revised August 1, 2010)

This is to certify that the Board of Trustees of the Southern California Lumber Industry Welfare Fund, at a meeting on October 30, 2018, did adopt the following amendment to the Select Choice Plan to specify the venue in which a lawsuit must be brought against the Fund, or its Board of Trustees. This Amendment is effective October 30, 2018.

1. Under the "Indemnity Medical Plan" section, a new subsection is added at the end of the section, following the "Time Limitation for Section 502(a) Lawsuit" subsection (as previously amended by Amendment No. 22), as follows:

"INDEMNITY MEDICAL PLAN

* * *

VENUE FOR LAWSUIT

Any lawsuit filed against the Southern California Lumber Industry Welfare Fund, or its Board of Trustees, including, but not limited to, a lawsuit under Section 502(a) of ERISA, must be brought solely and exclusively in the United States District Court for the Central District of California or the United States District Court for the Southern District of California. Please see the section of the booklet entitled "Benefit Claims and Appeal Procedures" for the detailed Benefit Claims and Appeal Procedures (pages 113 to 116 as amended by Amendments Nos. 5, 15, 22, 28, and 33)."

2. Under the "Prescription Drug Benefits" section, a new subsection is added at the end of the section, following the "Time Limitation for Section 502(a) Lawsuit" subsection (as previously amended by Amendment No. 23), as follows:

"PRESCRIPTION DRUG BENEFITS

* * *

VENUE FOR LAWSUIT

Any lawsuit filed against the Southern California Lumber Industry Welfare Fund, or its Board of Trustees, including, but not limited to, a lawsuit under Section 502(a) of ERISA, must be brought solely and exclusively in the United States District Court for the Central District of California or the United States District Court for the Southern District of California. Please see the section of the booklet entitled "Indemnity Prescription Drug Benefit Claims and Appeal Procedures" for the detailed Indemnity Prescription Drug Benefit Claims and Appeal Procedures (pages 117 to 124 as amended by Amendments Nos. 8, 16, 23, 28, and 33)."

3. Under the "Benefit Claims and Appeal Procedures" section, the "Miscellaneous Benefit Claim and Appeal Procedures" (as previously amended by Amendment Nos. 5, 15, 22, 28, and 33), a new subsection is added at the end of the section, following the "Time Limitation for a Section 502(a) Lawsuit" subsection, as follows:

"BENEFIT CLAIMS AND APPEAL PROCEDURES

* * *

Miscellaneous Benefit Claim and Appeal Procedures

* * *

Venue for Lawsuit

Any lawsuit filed against the Southern California Lumber Industry Welfare Fund, or its Board of Trustees, including, but not limited to, a lawsuit under Section 502(a) of ERISA, must be brought solely and exclusively in the United States District Court for the Central District of California or the United States District Court for the Southern District of California."

4. Under the "Indemnity Prescription Drug Benefit Claims and Appeal Procedures" section, the "Miscellaneous Benefit Claim and Appeal Procedures" (as previously amended by Amendment Nos. 8, 16, 23, 28, and 33), a new subsection is add at the end of the

section, following the "Time Limitation for a Section 502(a) Lawsuit" subsection, as follows:

"**Indemnity Prescription Drug Benefit Claims and Appeal Procedures**

* * *

Miscellaneous Benefit Claim and Appeal Procedures

* * *

Venue for Lawsuit

Any lawsuit filed against the Southern California Lumber Industry Welfare Fund, or its Board of Trustees, including, but not limited to, a lawsuit under Section 502(a) of ERISA, must be brought solely and exclusively in the United States District Court for the Central District of California or the United States District Court for the Southern District of California."

Executed this 30th day of October 2018.

Chairman

Secretary