LABOR-MANAGEMENT UNIVERSAL

HEALTH BENEFITS TRUST

Summary Plan Description

March 1, 2021

Administered by

Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724

Telephone: (800) 662-9265 • (562) 463-5005
Fax: (626) 279-3055

www.lmuhbt.com

LABOR-MANAGEMENT UNIVERSAL HEALTH BENEFITS TRUST

This Summary Plan Description (referred to in this booklet as "SPD") describes the benefit plan which is made available through the Collective Bargaining Agreement in effect between your employer and your Union under the Labor-Management Universal Health Benefits Trust (referred to in this SPD as "the Trust"). The health and welfare benefits offered under the Trust are administered by Pacific Southwest Administrators (referred to in this SPD as "Trust Fund Office").

This SPD is in effect as of March 1, 2021. Changes, revisions or modifications to this SPD made after March 1, 2021, will be communicated to you on an ongoing basis through written notices as such changes, revisions or modifications are adopted by the Board of Trustees.

Health and welfare benefits are provided under the Trust by way of contracts with various insurance companies. Specific benefit levels and other terms and conditions are contained separately in Evidence of Coverage ("EOC") or Certificate of Insurance Booklets issued by each insurer. Copies of these booklets are available at no charge from the Trust Fund Office at the address listed below. You should become familiar with the provisions of your particular plan of benefits by reading the EOC or Certificate of Insurance Booklets provided by the insurance carriers.

Employer contributions for the health and welfare benefits described in the enrollment materials and in this SPD are generally based on hours worked by active employees under a Collective Bargaining Agreement. These employer contributions finance the benefits offered by the Trust on a month-to-month basis.

Please understand that the health and welfare benefits described herein are not vested and do not involve any rights that may vest at any time in the future. **The Trustees reserve the right to change the eligibility rules, reduce the benefits, or eliminate the Trust, in whole or in part, as may be required by the circumstances.**

To obtain maximum benefits from the Trust, study this SPD carefully. We strongly recommend that you put this SPD, along with other notices that you receive from the Trust Fund Office, in a safe and convenient place. If you have any questions or need assistance in securing your benefits, please do not hesitate to call the Trust Fund Office at (800) 662-9265 or (562) 463-5005, or write to the Trust Fund Office or the Board of Trustees at the following address:

Labor Management Universal Health Benefits Trust
c/o Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724

Fax: (626) 279-3055 · www.lmuhbt.com

All questions about the Trust and requests for information from the Trust, must be made through the Trust Fund Office or the Board of Trustees at the telephone number and address indicated above. No participating employer, employer association, union or labor organization, or any individual employed thereby, has any authority in this regard.

Aviso A Los Participantes

Del Idioma Español

Este folleto contiene informes importantes acerca de sus beneficios del Trust de Salud y Bienestar, si tiene dificultad alguna en comprender cualquier parte de los informes, favor de llamar a la oficina administrativa al 800-662-9265 o visite la oficina que se encuentra ubicada en el 1055 Park View Drive, Suite 111, Covina, California 91724. El horario es de 8:30 a.m. a 5:00p.m., de Lunes a Viernes. Una persona que habla Español estara disponsible para ayudarle. Tambien para los que lo desean, estaran disponsibles copias del Trust en Español.

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I. Eligibility Rules

A. Initial Eligibility

The Trust provides eligibility to Active Employees for benefits starting with the month after the first month that contributions are received from an employer ("Eligible Employees"). The Trustees are empowered to create and enforce the rules pertaining to individual eligibility. The Trustees, in exercising their responsibilities, reserve the right to modify the eligibility requirements without prior notice. Retirees are not currently covered under the Trust.

Example: If an employee becomes employed on June 1 and the employer pays the required contributions and meets all Trust requirements for participation on or before June 15, that employee would then become eligible for benefits starting with the month of July.

Specific eligibility for participants covered by Collective Bargaining Agreements is determined according to the Provisions of the Collective Bargaining Agreements, including Side-Letter Agreements and Participation Agreements, between the various unions and employers participating in the Trust.

In no event may any Collective Bargaining Agreement impose an eligibility waiting period that is longer than 60 days from an employee's date of hire or rehire.

Non-Bargaining Unit Participants: Specific eligibility for non-bargaining participants is determined according to the Provisions of the Participation Agreements between those participants' employers and the Trust.

In no event may any employer impose an eligibility waiting period that is longer than 60 days after an employee's date of hire or rehire.

B. Termination of Employee Eligibility

Your coverage will terminate on the earliest of the following dates:

1. The first day of the month for which a contribution for coverage for that month was not received on your behalf

2. The date you enter into full-time military service, unless you qualify for continuing coverage and make appropriate payments, if required, under the law pertaining to military leaves of absence; or

3. The date the Plan terminates.

   When your coverage terminates, you may have the option of continuing your coverage under COBRA.

   Note: The Trust's rules regarding Dependent eligibility and termination are described below.

C. **Waiving Health Care Coverage**

After you have satisfied the rules for eligibility, you will be offered medical coverage under one of the available plans. Coverage may be waived for you and/or your dependents for any of the benefits provided under the Trust if-and only if-you provide the Trust Administrator with acceptable evidence of other group coverage under another plan not including Medi-Cal and and Medicare and such waiver is expressly permitted by the terms of your collective bargaining agreement, or for non-bargaining unit participants, your employer's participation agreement.

However, if you elect to waive coverage for you and/or your dependents, you will not be permitted to enroll in any plan of benefits under the Trust for a period of at least 12 months, unless you qualify for re-enrollment under the HIPAA Special Enrollment rules.

Additionally, if you and/or your dependents elect to enroll in benefits under the Trust, you will not be permitted to waive coverage for a period of at least 12 months, unless you qualify for re-enrollment under the HIPAA Special Enrollment rules or unless the dependent no longer meets the definition of Eligible Dependent.

A Waiver of Health Care form and additional information is available at the Trust Fund Office and at the Trust's website at www.lmuhbt.com.

D. **Enrollment for Benefits**

Everyone must be enrolled for benefits. No coverage will be provided, unless the proper forms are completed. **(Refer to the Section "Enrollment Rules" for important information.)**

E. Continuing Eligibility

You will remain covered during each month for which a contribution has been received on your behalf.

F. Military Leave of Absence

If you are on a military leave of absence from your employment, and the period of military leave is less than 31 days, you will continue to be eligible for coverage under this Plan during the 31-day leave with no self-payment required, provided you are in an eligible status under this Plan at the time your military leave begins.

If you are on a military leave of absence from your employment, and the period of military leave is longer than 31 days, you may continue to be eligible for continued coverage under the provisions of COBRA, provided you pay the applicable premium.

Upon release from active service, your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA"), described later in this SPD.

G. Dependents

1. Eligibility for Dependents

   Once you, an Employee, qualify for eligibility (initial and continuing eligibility), Eligible Dependents are also entitled to the benefits provided by the Trust, as long as you remain eligible. Eligible Dependents are defined below and will be covered under the same Medical, Vision, Dental, and Life Insurance programs as the Eligible Employee.

   Dependents acquired by you after the effective date of your own coverage become covered as of the date they become Eligible Dependents. All new dependents must be enrolled within 30 days of becoming Eligible Dependents, including newborn children. You may obtain the necessary forms to enroll new Eligible Dependents from the Trust Fund Office or at the Trust’s website at www.lmuhbt.com.

   Unless there is a life event that qualifies under the HIPAA Special Enrollment rules, failure to enroll a new dependent within 30 days will result in no coverage for the Dependent until the annual Dependent Open Enrollment period, which is generally during January of each year for coverage beginning March 1st.

2. Definition of Eligible Dependent

   An Eligible Dependent is your—

   a. legal Spouse or your registered Domestic Partner,
   b. your natural or legally adopted Dependent Children and/or children under legal guardianship, or
   c. your Spouse's or your registered Domestic Partner's natural children, legally adopted children, and/or children under legal guardianship. A Spouse is the person whose marriage to you is recognized by California Law. A Domestic Partner is the person who is your registered Domestic Partner under the Laws of the State of California.

      Appropriate documentation, including, but not limited to, an official government-issued Marriage Certificate, Birth Certificate, and other proof of eligibility must be provided to the Trust Fund Office in order to enroll Eligible Dependents. Participants and Eligible Dependents may also be subject to periodic eligibility audits. The appropriate documentation and proof of eligibility for enrollment and periodic audits are:

      For a spouse,

      a Copy of Legal Marriage Certificate

      and one of the following:

      - A copy of the front page of the most current federal tax return confirming this dependent is your spouse,

      or

      - A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account. The document must list your spouse's name, the date and your mailing address.

        Note: Healthcare bills will not be accepted as proof of eligibility as healthcare coverage is being validated.

      For a Domestic Partner,

      a copy of your State registered Declaration of Domestic Partnership,

      and

- A document dated within the last 60 days showing current relationship status, such as a recurring household bill or statement of account. The document must list your partner's name, the date and your mailing address.

  Note: Healthcare bills will not be accepted as proof of eligibility as healthcare coverage is being validated.

For children up to age 26,

a copy of the child's Birth Certificate or Adoption Certificate naming you or your spouse as the child's parent (first and last names listed),

or

- A copy of the Court Order naming you or your spouse as the child's Legal Guardian.

For Disabled Children age 26 or older:

- A copy of the child's Birth Certificate or Adoption Certificate naming you or your spouse as the child's parent (first and last names listed)

or

- a copy of the Court Order naming you or your spouse as the child's Legal Guardian,

and

- A copy of the front page of the most current federal tax return showing the Dependent claimed as your exemption.

Eligible Dependent Children will be covered up to their 26th birthday irrespective of their eligibility for other employer-sponsored health coverage. You and your Dependent Child are responsible for providing the Trust Fund Office with proof of eligibility and any other documentation required to verify Dependent eligibility.

Note: We strongly urge you to contact a qualified tax professional before enrolling an Eligible Dependent regarding any tax consequences that may result due to enrollment of such an individual in the Trust.

H. Termination of Dependent Eligibility

Dependent Eligibility will terminate upon the earliest of the following dates:

1. When the Employee ceases to be eligible, **or**
2. The date the individual no longer qualifies as an Eligible Dependent, **or**
3. The date the Eligible Dependent enters into full-time military, naval, or air service, **or**
4. In the event of legal separation or divorce, your legal Spouse's eligibility will terminate as of the date of dissolution, **or**
5. The date the Trustees terminate coverage for Dependents, **or**
6. Your Eligible Dependent Child's 26th birthday.

Note: When an Eligible Dependent's eligibility terminates, he or she may have the right to elect COBRA Continuation Coverage, which is described in detail below.

Important Reminder Regarding Changes in Dependent Status

You must IMMEDIATELY notify the Trust Fund Office in writing when changes in Eligible Dependent status occur. This includes final Dissolution of Marriage or termination of Domestic Partnership, legal separation, death of a dependent, or any other event which would make your Dependent not eligible for coverage.

If you do not immediately notify the Trust Fund Office and claims and/or premiums are paid on behalf of an ineligible Dependent, you and/or the Dependent are responsible for reimbursing the Trust for such claims and/or premiums, including attorney's fees, interest and reasonable collection costs.

The Trust may recover these amounts through legal action or otherwise, as determined in the sole and absolute discretion of the Board of Trustees or a duly authorized committee thereof. You and/or the Dependent may also be required to reimburse the Trust and/or benefit provider for the value of any benefits provided to an ineligible Dependent.

I. Domestic Partner Coverage

The Trust provides coverage for Domestic Partners of Eligible Employees. As with spousal coverage, there are a number of requirements that must be met in order to enroll a Domestic Partner in the Trust. Under California Law, a Domestic Partner is established when both persons file a Declaration of Domestic Partnership with the Secretary of State and all of the following

requirements are met:

1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity,

2. The two persons are not related by blood in a way that would prevent them from being married to each other in this State,

3. Both persons are at least 18 years of age,

4. Either of the following:

    a. Both persons are members of the same sex, or

    b. One or both of the persons are over age 62 and one or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title VXI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals, and,

    c. Both persons are capable of consenting to the domestic partnership**.**

Note: There are tax implications associated with Domestic Partner coverage. The value of the coverage could be subject to taxation under Federal, as well as State Law. We strongly recommend you consult with a qualified tax professional regarding your particular situation, prior to enrolling a Domestic Partner.

II. Enrollment Rules

A. General Rules

When you become eligible, the Trust Fund Office will furnish you with an Enrollment & Beneficiary Form. All benefits provided by the Trust are fully insured. Currently, the Trust has contracted with the following insurance carriers for benefits:

TYPE OF BENEFIT	INSURANCE CARRIERS
Medical, Surgical, and Prescription	• Kaiser Permanente www.kaiserpermanente.org (800) 464-400**0** • Health Net of California www.healthnet.com (800) 522-0088
Dental	LIBERTY Dental Plan www.libertydentalplan.com (888) 703-6999
Vision	Vision Service Plan (commonly referred to as “VSP”) www.vsp.com
Life Insurance	The Hartford previously “Aetna” www.thehartford.com

In addition to the Enrollment & Beneficiary Form, you must also complete enrollment forms for each of the medical providers listed above. These forms will be provided to you by the Trust Fund Office when you become eligible. In addition, you may obtain enrollment forms from the Trust Fund Office at any time upon request.

Note: You cannot be properly enrolled for benefits until the Trust Fund Office receives the necessary completed forms. Therefore, it is your obligation to contact the Trust Fund Office to make sure that you have properly completed the necessary forms. A failure to properly and timely enroll may mean that you and your dependents will not be covered by the Trust or receive benefits.

B. **Twelve-Month Rolling Enrollment – Effective March 1, 2021**

The Board of Trustees adopted a Twelve (12)-Month Rolling Enrollment, effective March 1, 2021. You are able to make changes to your medical/dental/vision plans (if applicable), once in every twelve (12)-month

rolling period from the date of your last change, provided you have participated in the same plan for at least twelve (12) months. Changes are effective the first day of the month following the date the Trust Fund Office receives the selection card and appropriate HMO enrollment form.

You must complete the selection card indicating the change in coverage and the appropriate HMO enrollment form, which is provided by your employer or the Trust Fund Office. If you qualify for any of the Trust's special enrollment periods described below, you may also add or remove Dependents during the time period described below.

Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly completed and submitted to the Trust Fund Office within thirty (30) days from the date you are eligible to change your medical plan.

The Trust Fund Office can provide you with information regarding the benefit options available to you, including brochures which describe the medical, dental, vision and life insurance benefits provided by each insurance company with whom the Trust has contracted for the provision of benefits. You may also add or remove Dependents during the Open Enrollment period, which is generally during January of each year for coverage beginning March 1st.

Note: If you move or are no longer in the service area of one of the insurance providers, you should notify the Trust Fund Office.

III. HIPAA Special Enrollment Rules

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that if you fail to enroll for a plan or have elected not to enroll your Dependents, you will have the option to enroll under the following circumstances:

A. When you marry or add a Spouse or Domestic Partner; or
B. When you have a new Eligible Dependent (either as a result of birth, adoption, or marriage to a person who has children); or
C. When your legal Spouse or Domestic Partner was covered under another group health plan and lost eligibility, exhausted COBRA Continuation Coverage, or there was a substantial change in the coverage or cost so that the Spouse or Domestic Partner could no longer be covered.

Note: You must notify the Trust Fund Office of your request for special enrollment under HIPAA within 30 days after an Eligible Dependent loses

their other coverage or within 30 days of having (or becoming) a new Eligible Dependent.

IV. Special Enrollment under Children's Health Insurance Program

Effective April 1, 2009, a special 60-day enrollment period is added for an Eligible Dependent who meets the definition of a "qualifying child", if he or she—

A. loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") Coverage under State Law, or
B. becomes eligible to participate in a premium assistance program under Medicaid or CHIP. You must request enrollment in the Trust within sixty (60) days of loss of Medicaid or CHIP, or of the eligibility determination.

The Trust cannot answer questions concerning your rights under State-Sponsored Programs. The State of California or the state of your residency can assist you with Medicaid or CHIP eligibility questions. More information regarding CHIP is also available through the Federal Government at www.insurekidsnow.gov as well as Covered California at www.coveredca.com.

V. Subrogation & Reimbursement

The Trust does not provide coverage or benefits for any medical need caused by an act or omission of a third party. If an Eligible Employee or an Eligible Dependent is injured through the act or omission of a third party and payment is made by that party (or his or her insurance company), such an individual or his or her trustee, representative, parent, child or any successor or representative in interest, the Eligible Employee or Eligible Dependent must do all of the following:

A. Immediately report the event to the Trust Fund Office, including whether he or she intends to pursue a legal claim against the third party,
B. Subrogate (meaning transfer and assign) to the Trust any and all of your rights to recover any claims or "causes of actions" the Eligible Employee or Eligible Dependent may have against any third party,
C. Reimburse the Trust up to the actual benefits paid by the Trust for medical expenses arising from the act or omission of the third party, and,
D. Cooperate and do everything necessary to enable the Trust to enforce its subrogation and reimbursement under this Section.

The Eligible Employee or Eligible Dependent or any individual or entity acting on his or her behalf (referred to in this section as "Claimant"), must reimburse the Trust even if the amount the Claimant recovers from the third party is less than the full amount of the funds expended by the Trust in connection with such medical needs. The Reimbursement and Subrogation Rights described in this Section will have first

priority and will apply regardless of whether any amount recovered by the Claimant from a third party are characterized as or deemed to be medical expenses or not.

Furthermore, the Trust's rights of subrogation and reimbursement will apply to the proceeds of any source of recovery by the claimant, including, but not limited to, a responsible party or responsible party's insurer (or any form of self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, workers' compensation, or any individual policy of insurance or protection maintained by the Claimant.

If the Trust makes a payment or becomes obligated to make a payment arising from an act or omission of a third party, the Claimant hereby consents to the placement of a constructive trust and an equitable lien on the proceeds of any payment, settlement or judgment received by the Claimant from any source in connection with the illness, injury, or medical need.

Eligible Employees and Eligible Dependents agree, on their behalf and on behalf of any Claimant acting on his or her behalf, that Claimant will hold any funds that are subject to subrogation or reimbursement under this Section in trust for the benefit of the Trust. Such trust may not be assigned, amended, dissolved, transferred, merged or terminated until and unless the Trust is reimbursed in full for any and all expenses it has incurred related directly or indirectly to the act or omission of the third party, including, but limited to, the payment of medical expenses or providing of benefits and costs, attorney fees, and expenses it has incurred in securing reimbursement or subrogation.
Eligible Employees and Eligible Dependents agree on behalf of themselves and their Claimants, that the Claimant will not do anything to impair, release, discharge or prejudice the Trust's rights, actions or attempts under this Section.

In this regard, the Trust's rights relating to subrogation and reimbursement will not be limited by any "make-whole" doctrine or "common-fund" doctrine available to Claimant under State or Federal Law.

You further acknowledge the right of the Board of Trustees to require from you and promptly receive proof of eligibility status, such as Marriage Licenses, Birth Certificates, Domestic Relations Decrees or any other proof of eligibility as the Board of Trustees, in its sole discretion, may demand. You agree to promptly furnish such proof to the Board of Trustees and further agree that furnishing such proof satisfactory to the Board of Trustees is a precondition to the payment of any benefits for you or on your behalf, or on behalf of your Dependents.

If the Trust pays benefits for you or on your behalf, or for any person enrolled as a Dependent when you or such person are not in fact eligible, you agree to promptly

reimburse the Trust in full for any monies so paid. You also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from your future benefits. If the Trust files any legal action against you to recover any such monies, you agree to pay all attorneys' fees and costs the Trust incurs, whether or not such an action proceeds to judgment.

Note: Due to the complex, technical and legal nature of Reimbursement and Subrogation, we strongly recommend that you consult with an attorney or other appropriate professional to determine your rights and obligations under this Section in any given situation. You may also call the Trust Fund Office for general information, but please be aware that the Trust will not be able to provide you any legal advice regarding any particular situation.

VI. Other Important Facts

A. Medical Examination

No medical examination is required. Eligible Employees and their Eligible Dependents will be covered regardless of their physical condition.

B. Beneficiary Designations

Every Eligible Employee should be certain to designate a beneficiary to receive benefits in the event of his or her death, if applicable. Beneficiary forms are available from the Trust Fund Office and Local Union Office.
If you wish to change your beneficiary, please request a blank form from the Trust Fund Office, fill it out completely and return it to the Trust Fund Office. This form may also be downloaded from the Trust's website at www.lmuhbt.com. A new form is not necessary for a change in address, but you must advise the Trust Fund Office of such change on a Change of Address form available from the Trust Fund Office or the Local Union Office.

C. Financing

Benefits are provided through various insurance providers under contract with the Trust Fund. Funds for this purpose are accumulated from employer contributions primarily through Collective Bargaining Agreements and Participation Agreements.

D. Active Employees Who Enter the Uniformed Services

If an Eligible Employee enters the Uniformed Service, the Eligible Employee and his or her Eligible Dependents will be provided continuation of coverage

under the Trust and Reinstatement Rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

The maximum period of continuation coverage for health care under USERRA is the lesser of—

1. 24 months (beginning from the date you leave work due to your military leave) or
2. the day after the date you fail to timely apply for or return to a position of employment with an employer participating in the Trust.

   Generally, your right to continuation coverage is governed by COBRA, as described below, with the exceptions noted in this paragraph. **First,** COBRA generally provides a maximum continuation coverage period of eighteen (18) months, while under USERRA this time period is extended by an additional six (6) months, to bring the total period of coverage to twenty-four (24) months. **Second,** under USERRA, if your military leave is less than thirty-one (31) days, you will continue to be eligible for coverage as provided on page 1. **Third,** if you become covered by another group health plan or entitled to Medicare during the USERRA maximum coverage period described above, the continuation coverage elected by you and your Dependents will not be terminated.

E. **Industrial Illness or Injury**

Benefits will not be paid for any illness or injury covered by any Workers Compensation Statute or similar statutory provision. Important items to remember in connection with this include:

1. If you or an Eligible Dependent suffers an industrial injury or illness and obtains an Award before the Workers Compensation Appeals Board, that Award is your total compensation for the injury or illness. The Trust will not provide benefits for expenses in connection with the injury or illness.
2. If the Eligible Employee or Eligible Dependent elects not to seek a Workers' Compensation Award for an industrial illness or injury, the Trust will not provide benefits for expenses in connection with the illness or injury.
3. If the Trust provides benefits for the treatment of an industrial illness or injury, the Trust will have a lien against any Workers' Compensation Award received, to the extent of the benefits provided. The Trust will additionally have the right to subrogation and reimbursement as described in Section V above.

F. Evidence of Coverage Booklets & Policies

The specific benefits available under the Trust are established under the various Evidence of Coverage ("EOC") booklets and Policies issued by the various insurance carriers, listed above, with whom the Trust has contracted for providing health and welfare benefits.

G. Coordination of Benefits

Medical, dental, vision and prescription drug benefits are coordinated with those provided for the Eligible Employees and Eligible Dependents by any other group, hospital, medical benefit or service plan. The necessary information will be provided by the benefits provider, if this provision applies to your particular claim or situation. For example, if, in addition to receiving coverage from a plan of benefits offered under the Trust, your spouse is covered by a plan of benefits offered by his or her employer, the EOC booklets for each such plan will describe how benefit payments will be coordinated. The Trust will not get involved in the coordination of benefits.

H. Qualified Medical Child Support Orders (QMCSO)

The Trust is required to provide benefits pursuant to a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a judgment or decree by a court of competent jurisdiction (or of a state or local administrative agency established under state law that has the force and effect of law under applicable state law) that requires a group health plan to provide coverage to the children of an Eligible Employee pursuant to a State Domestic Relations Law.

1. If a court has issued an Order with respect to the provision of health care coverage for any of the Eligible Employee's Eligible Dependent Children, you must submit the Order to the Trust Fund Office. The Trust Fund Office or its designee will determine if the court order is a QMCSO as defined by Federal Law, and that determination will be binding on the Eligible Employee.

2. An Order is not a QMCSO if it requires the Trust to provide any type or form of benefit or any option that the Trust does not otherwise provide, or if it requires an Eligible Employee who is not covered by the Trust to provide coverage for a Dependent Child, except as required by a State's Medicaid-Related Child Support Laws.

3. If an Order is determined to be a QMCSO, and if the Eligible Employee is covered by the Trust, the Trust Fund Office or its designee will notify the

parents and each child and advise them of the Trust's Procedures that must be followed to provide coverage of the Dependent Child(ren). However, no coverage will be provided for any Dependent Child under a QMCSO unless the applicable Eligible Employee contributions for that Dependent Child's coverage are paid, and all of the Trust's requirements for coverage of that Dependent Child have been satisfied.

For further details regarding QMCSOs, or to submit an Order that you believe is a QMCSO, please contact the Trust Fund Office at the following address and telephone numbers:

Labor-Management Universal Health Benefits Trust
c/o Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724
www.lmuhbt.com

Telephone: (800) 662-9265 · (562) 463-5005
Fax: (626) 279-3055

VII. Family and Medical Leave Act (FMLA)

The extension of eligibility during a period of disability provided by the Trust under this Section does not replace or substitute any obligation that your employer may have under the FMLA. In the event your coverage is continued under FMLA, the Trust's extension of eligibility during a period of disability will start at the end of the FMLA coverage period provided all conditions stated above and all applicable legal requirements have been satisfied.

Re-qualification upon Return to Work:

In order to qualify for a new extension period, you must return to work and have regained eligibility for benefits for a minimum period of 60 days. The same rules for submitting proof of disability will apply in the event that you re-apply for a disability extension.

VIII. Newborns' & Mothers' Health Protection Act of 1996

Under Federal Law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (For example, your physician, nurse

midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal Law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal Law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Trust Fund Office or your insurance provider.

IX. Women's Health & Cancer Rights Act of 1998

The Women's Health & Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical benefits for a mastectomy, and if you were to need a mastectomy, you would also be covered for—

A. Reconstruction of the breast on which the mastectomy was performed,
B. Surgery/reconstruction on the other breast to produce a symmetrical appearance, and
C. Prostheses and/or physical complications that may arise, including lymph edemas.

X. COBRA Continuation Coverage

A. Introduction

This section has important information about your right to COBRA Continuation Coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA Continuation Coverage.

The right to COBRA Continuation Coverage was created by a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under Federal Law, you should review this Section of the SPD. If you have further questions, please contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

B. COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse or Domestic Partner, and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse or Domestic Partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse or Domestic Partner dies,
- Your Spouse's or Domestic Partner's hours of employment are reduced,
- Your Spouse's or Domestic Partner's employment ends for any reason other than his or her gross misconduct,
- Your Spouse or Domestic Partner becomes entitled to Medicare benefits (under Part A, Part B, or both) or
- You become divorced or legally separated from your Spouse or end your domestic partnership with your Domestic Partner.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both),
- The parents become divorced or legally separated or
- The child stops being eligible for coverage under the Plan as a Dependent Child.

C. **When COBRA Continuation Coverage Is Available**

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment,
- Death of the employee,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the qualifying event. You must provide this notice to—

Labor-Management Universal Health Benefits Trust
c/o Trust Fund Office
Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724

Telephone: (800) 662-9265 or (562) 463-5005
Fax: (626) 279-3055

D. **How COBRA Continuation Coverage Is Provided**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent

right to elect COBRA Continuation Coverage. Covered employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended:

Disability Extension of 18-month Period of COBRA Continuation Coverage

If you or anyone in your family, covered under the Plan, is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional eleven (11) months of COBRA Continuation Coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. You must send notice of such a disability to—

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c/o Trust Fund Office
Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724

Telephone: (800) 662-9265 or (562) 463-5005
Fax: (626) 279-3055

Second Qualifying Event Extension of 18-month period of Continuation Coverage

If your family experiences another qualifying event during the eighteen (18) months of COBRA Continuation Coverage, the Spouse and Dependent Children in your family can get up to eighteen (18) additional months of COBRA Continuation Coverage, for a maximum of thirty-six (36) months, if—

- the Plan is properly notified about the second qualifying event.

This extension may be available to the Spouse or Domestic Partner and any Dependent Children getting COBRA Continuation Coverage if—

- the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if
- the Dependent Child stops being eligible under the Plan as a Dependent Child.

This extension is only available if the second qualifying event would have caused the Spouse or Domestic Partner or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

E. Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "Special Enrollment Period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

F. If You Have Questions

Questions concerning your Plan, or your COBRA Continuation Coverage Rights, should be addressed to the Trust Fund Office. For more information about your rights under the Employee Retirement Income Security Act ("ERISA"), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.healthcare.gov.

Labor-Management Universal Health Benefits Trust
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Fax: (626) 279-3055

G. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Trust Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Trust Fund Office:

Labor-Management Universal Health Benefits Trust
c/o Trust Fund Office
Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724
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Fax: (626) 279-3055

H. Continuation of Health Benefits after COBRA

Under California Law, HMOs providing group health coverage in California are required to offer to continue benefits for certain individuals beyond the period extended by COBRA. You and/or your Dependent may be eligible for such coverage if you pay the full cost of the continuation coverage, if the COBRA Qualifying Event resulted in fewer than 36 months of continued coverage, and you exhausted your initial COBRA Continuation period of coverage.

You and/or your Dependent(s), or your former Spouse, must elect the extended coverage by notifying your HMO in writing, no less than 30 days before continuation coverage under COBRA would end. For more information regarding post-COBRA Continuation Coverage, including additional eligibility requirements and cost, contact your HMO.

XI. Health Insurance Portability & Accountability Act of 1996

The Trust is committed to protecting the privacy of your medical information as required the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rules and regulations adopted thereunder. If the privacy rules under HIPAA are changed or amended, the Trust will follow the revised rules.

The Trust may use and disclose Protected Health Information ("PHI") for Public Health, Law Enforcement, or Legal Process purposes under the following conditions:

- The Trust may disclose this information without the consent or authorization of the individual who is the subject to the information.
- The Trust is not required to give the individual the opportunity to agree or object to the use or disclosure.
- These uses and disclosures must comply with the Minimum Necessary Rule, that is, the information used or disclosed must be limited to that minimally necessary to accomplish the business purpose. (Only uses and disclosures required by law are not subject to the Minimum Necessary Rule.)
- In all cases involving these uses and disclosures, the Privacy Official or his or her designee must review and authorize the use or disclosure.
- Verification of the identity of public officials requesting PHI should be made pursuant to the Trust's Verification Policies and Procedures.
- The uses and disclosures listed below are permitted by the HIPAA Privacy Rules, but the Trust reserves the right to refuse to make the disclosure or to seek legal guidance regarding whether the disclosure should be made, including but not limited to seeking guidance from a court of applicable jurisdiction.

A. **Uses & Disclosures Required by Law**

The Trust may use or disclose PHI to the extent that the use or disclosure is required by law. The use or disclosure must comply with and be limited to the relevant requirements of the law. If the use or disclosure is to report abusive situations, to comply with judicial or administrative legal process, or for law enforcement purposes, the use or disclosure must also comply with these Policies and Procedures. Uses and disclosures that are required by law are not subject to the minimum necessary rule. **For example**, the Trust may disclose PHI pursuant to an administrative subpoena, but the PHI must be limited to that authorized to be disclosed on the face of the subpoena.

B. **Public Health Records**

The Trust may disclose PHI to public health authorities authorized by law to collect or receive PHI for the purpose of disease control or prevention. This includes but is not limited to the following:

- Reporting disease or injury
- Reporting vital events such as birth or death
- Conduct of public health surveillance
- Conduct of public health investigations
- Conduct of public health interventions

The Trust may disclose PHI at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.

C. **Child Abuse or Neglect**

The Trust may disclose PHI to public health authorities or other appropriate government authority authorized by law to receive reports of child abuse or neglect.

D. **Safety Law Reporting & Employer Medical Surveillance**

The Trust may need PHI in order to comply with its obligations under State and Federal Law, including the Occupational Safety and Health Act ("OSHA"), and similar state laws that require us to record illness or injury to carry out responsibilities for workplace medical surveillance. The Trust will, from time to time, employ or hire a covered health care provider to assist us with these federal and state disclosure obligations, and for the following purposes:

- To conduct an evaluation relating to medical surveillance of the workplace; or
- To evaluate whether the individual has a work-related illness or injury

E. **Victims of Abuse, Neglect or Domestic Violence**

The Trust will disclose PHI about an individual whom the Trust reasonably believes to be a victim of abuse, neglect or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence. Disclosure will be made only—

1. After authorization by the individual; or
2. To the extent required by law and to the extent that the disclosure complies with the law; or
3. If expressly authorized by statute or regulation; and
4. If the Trust believes in the exercise of professional judgment, that the disclosure is necessary to prevent further harm to the victim or other people, or a public official represents that an investigation will be adversely affected by waiting for authorization by the individual and that disclosure will not be used against the individual.

The Trust must inform the individual of any disclosure, unless the Trust believes informing the individual would place the individual at risk of serious harm, or if the Trust would be informing a personal representative who the

Trust believes is responsible for the abuse or injury and informing the representative would not be in the best interests of the individual.

This section does not apply to reports of child abuse or neglect, which is addressed in subsection C above.

F. **Health Oversight Activities**

The Trust will disclose PHI to a Health Oversight Agency for oversight activities authorized by law, such as audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of—

1. The health care system,
2. Government benefit programs for which health information is relevant to beneficiary eligibility,
3. Entities subject to government regulation for which health information is necessary for determining compliance with program standards or
4. Entities subject to Civil Rights Laws for which health information is necessary for determining compliance.

The Trust will not disclose PHI for an investigation or other activity in which the individual is the subject of the investigation, and the investigation is not related to the receipt of health care, a claim for public benefits related to health, or qualification for or receipt of public benefits or services when a patient's health is integral to the public benefits or services.

Health Oversight Agencies include an agency or authority of the United States, including the Department of Labor, a State, a territory, a political subdivision of a State or territory, or an Indian Tribe that is authorized by law to oversee the health care system (both public and private) or government programs described in this Section.

G. **Disclosure in Response to a Court Order**

The Trust will disclose PHI in the course of any judicial or administrative proceeding in response to an Order of a Court or Administrative Tribunal. The Trust will disclose only the PHI expressly authorized by such order.

H. **Disclosure in the Course of Judicial Proceeding without a Court or Administrative Order**

The Trust will not disclose PHI in response to a subpoena, discovery request or other lawful process unless the Trust verifies that the individual is aware of

the request and has not made a valid objection to it, in accordance with the rules set forth in this Section. **Legal Counsel will be consulted when a subpoena, discovery request, or other lawful process is received.**

The Trust will disclose PHI in response to a subpoena, discovery request, or other lawful process, not accompanied by an Order of a Court or Administrative Tribunal, only if the Trust receives "written documentation" from the party seeking the PHI, that reasonable efforts have been made to ensure that the individual who is the subject of the PHI has been given notice of the request and either did not object or a court overruled the objection.

Written documentation means a statement by the requestor that—

- The party requesting disclosure has made a good faith attempt to provide written notice to the individual whose PHI is being sought, or if the individual's location is unknown, has mailed a notice to the individual's last known address,
- The notice included sufficient information to allow the individual to go to court and object to the release, and
- The time for objections has expired or the court has resolved the objections.

The Trust will also disclose PHI in response to a subpoena, discovery request or other lawful process, if the parties have agreed to a Qualified Protective Order and have presented it to a Court or Administrative Tribunal, or if the party seeking the PHI has requested a Qualified Protective Order from such a Court or Administrative Tribunal. A Qualified Protective Order means an order of a Court or Administrative Tribunal or a stipulation by the parties that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which the PHI was requested. It must also require the return or destruction of the PHI (including all copies made) at the end of the proceeding.

I. **Law Enforcement Purposes**

The Trust will disclose PHI for law enforcement purposes to a law enforcement official. The Privacy Officer will be responsible for this disclosure and must take reasonable steps to verify that an individual is a member of a law enforcement entity.

The Trust will disclose PHI as required by and as relevant to the following legal process:

- A Court Order, Court-Ordered Warrant or Subpoena, or Summons issued by a Judicial Officer,
- A Grand Jury Subpoena, or
- An administrative request, including an Administrative Subpoena or Summons, or a civil or authorized investigative demand, or similar process under law, if the PHI sought is relevant to a legitimate law enforcement inquiry, the request is specific and limited to the purpose for which the information is sought, and certification is made that de-identified information could not be used.

The Trust will disclose PHI about an individual in response to a law enforcement official's request for such information, for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, **but the Trust will supply only the following information**:

1. Name and address,
2. Date and place of birth,
3. Social security number,
4. ABO blood type and Rh factor,
5. Type of injury,
6. Date and time of treatment,
7. Date and time of death, if applicable, and
8. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

The Trust will not disclose for the purposes of identification or location, any PHI related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

J. **PHI of Victims**

The Trust will disclose PHI in response to a law enforcement official's request about an individual who is, or is suspected to be a victim of a crime if—

- The individual agrees to such disclosure, or
- The individual is unable to agree due to incapacity or other emergency circumstance, the law enforcement official must represent that PHI is needed to determine whether a violation of law by someone other than the victim has occurred, that such information is not intended to be used against the victim, that immediate law enforcement activity which depends upon the disclosure would be materially and adversely affected by waiting

until the individual is able to agree to the disclosure, and that disclosure is in the best interests of the person.

The Trust will also disclose PHI about a deceased individual to law enforcement authorities, if the Trust suspects the individual's death resulted from a criminal act. The Trust will disclose PHI if the Trust has a good faith belief that it is evidence of a crime on their premises.

K. **Other Entities**

The Trust will provide PHI to a coroner or medical examiner for the purpose of identification of a deceased person, determination of cause of death, or the coroner's other duties as authorized by law. The Trust will also disclose PHI to funeral directors as necessary for fulfillment of their duties. If necessary, PHI may be disclosed prior to, and in anticipation of the individual's death. The Trust will disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

L. **Workers' Compensation**

The Trust may disclose PHI as authorized and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. Workers' Compensation Disclosures that are required by law are not subject to the Minimum Necessary Rule.

M. **Compliance with HIPAA**

The Trust must permit Department of Health and Human Services ("HHS") access during normal business hours to our facilities and information, including PHI, which is pertinent to ascertaining compliance with the applicable requirements of HIPAA. If HHS determines that exigent circumstances exist, such as the destruction of documents, the Trust must permit access at any time without notice.

Disclosures made to HHS in accordance with a HIPAA Compliance Investigation are not subject to the Minimum Necessary Rule.

If any information required of us under this section is in the exclusive possession of any other agency or person, and the other agency or person fails or refuses to furnish the information, the Trust must exhibit what efforts have been made to obtain the information.

XII. Mental Health and Substance Abuse Parity

Your medical plan will provide medically necessary services for treatment of mental health and substance abuse to the same extent as benefits would be provided for other medically necessary treatment for other diseases.

XIII. Claims and Appeals Procedures

No employee, participant, dependent or other beneficiary shall have any right or claim to benefits under the Trust, except as specified in this SPD, or the Trust's Trust Agreement. Any dispute as to eligibility, type, amount or duration of benefit under the Trust, or any amendment or modification thereof, shall be resolved by the Board of Trustees or the designated insurance carrier or benefits provider, and the decision of that entity shall be final and binding upon parties to the dispute, subject to the rights of Eligible Employees, Eligible Dependents and other beneficiaries' rights, to bring suit in State or Federal Court.

Note: Most, if not all, applications or claims for benefits should be made directly to the benefits provider or insurer. In the rare instance that your claim or application needs to be presented to the Trust Fund Office or the Board of Trustees, the Section below describes procedures for presenting such a claim or application for benefits.

A. Requirements Applicable to All Claims

Employees, Dependents and all other beneficiaries must follow the Claims and Appeal Review Procedures as follows:

1. Submit a written claim for benefits,
2. Receive notification whether the application is granted or denied,
3. If application is denied in full or in part, file a written request for a review of the application through all levels of appeals with the Trust Fund Office or the appropriate benefits provider or insurance carrier, as applicable and
4. Receive notification in writing that the benefits provider or insurance company or Trust has confirmed the denial of the claim.

Finally, if there is a claim for benefits which is denied or ignored, in whole or in part, which the Eligible Employee, Eligible Dependent or other beneficiary has appealed through all levels of appeal through the Trust Fund Office or insurance carrier, the Eligible Employee, Eligible Dependent or other beneficiary may file a suit in a State or Federal Court.

Note: No legal action may be commenced or maintained against the Trust or the Board of Trustees, more than two (2) years after a claim has been denied.

B. **Specific Procedures Based Upon Type of Claim**

As stated above, in the rare instance that your claim needs to be brought before the Board of Trustees, the Trust has adopted the following Claims Procedures depending on the nature and type of your claim. **There are generally four types of claims:** Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims, and Post-Service Claims. Unless otherwise specified and established by the claimant, Eligibility Claims will be processed as post-service claims.

1. Urgent Care Claim

   An "Urgent Care Claim" is a pre-service claim for medical care or treatment that, if the normal pre-service claim standards of the Trust were to be applied, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. An Urgent Care Claim will generally be decided within 72 hours of the submission of the claim. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

2. Concurrent Care Claim

   In cases where the Trust has previously approved an ongoing course of treatment to be given over a period of time or number of treatments, any reduction in that course will be considered an adverse benefit determination. In the event of such an adverse benefit determination, the Trust will give you notice, sufficient time to appeal a determination and time to receive a decision of the appeal before an interruption of your care.

   In cases where the Trust has approved an ongoing course of treatment and you seek to extend the treatment beyond what has already been approved by the Trust, if the treatment requested is for urgent care, the decision of the Trust will be made in accordance with the same expedited procedures for determination of Urgent Care claims. If the request is made at least 24 hours before the end of pre-approved treatment, the Trust will notify you of the Trust's decision as soon as possible but no later than 24 hours after receipt of your claim.

3. Pre-Service Claim

   Claims for non-urgent care that require pre-authorization before care is obtained will be decided by the Trust within 15 days of receipt of a completed claim by the Trust Fund Office. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

4. Post-Service Claim

   Post-Service Claims are claims for reimbursement for care, which you have already received. Post-Service Claims will be determined within 30 days from receipt of the claim by the Trust Fund Office. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

C. **Denial of Claim**

If an application for a benefit or claim under the terms of the Trust is denied, in whole or in part, the Trust Fund Office shall send a written notice to you.

The notice will—

1. describe the specific reason or reasons for the denial,
2. reference the specific Plan provisions on which the denial is based, and any additional material or information necessary for you or your representative to perfect the claim,
3. provide an explanation of the reason why such material or information is necessary and
4. explain the Trust's Appeal Procedures, including the Trust's Expedited Appeals Procedure for Urgent Care Claims, and the applicable time limits for both appeal and determination of the appeal by the Board of Trustees, and
5. advise you that you are entitled to file suit in State or Federal Court after you have completed the appeal process described in this section.

If any internal rule, guideline or Plan procedure was relied upon in making the adverse benefit determination, the rule or guideline will be provided or a statement will be included that the specific rule was relied on and is available to you free of charge, upon your request.

If the adverse benefit decision was based upon lack of medical necessity or experimental or similar exclusion, the Trust will provide an explanation of the

scientific or clinical judgment made and will apply it to the terms of the Trust and your specific medical condition or will notify you that the information is available free of charge, upon request.

D. **Appeals Procedure**

If your claim has been denied (an adverse benefit determination), you will have 180 days from the denial of the claim to file a written appeal with the Trust Fund Office requesting a review by the Board of Trustees which must contain a written explanation of the basis for the appeal, and may include written comments, documents, records and other information relating to the claim.

You or your authorized representative may request that the Trust Fund Office provide copies of all documents, records, and other information relevant to the claim free of charge. The Board of Trustees will review and consider all comments, documents, records and other information submitted by you, whether or not such information was submitted in connection with the initial determination of your claim. The review by the Board of Trustees will consider all information and documents submitted by the claimant and will not defer to the judgment of the Trust Fund Office in deciding the appeal.

When the decision of the Trust Fund Office is based on medical judgment, the Board of Trustees will consult with an expert in the relevant field with appropriate training and experience, who did not participate in the original determination by the Trust Fund Office. The Board of Trustees will disclose the identity of each expert consulted by the Trust, whether such expert was relied upon or not in making the final decision on appeal.

At the time of filing the written appeal, you or your authorized representative may request a formal hearing before the Board of Trustees.

1. Procedure for Appeal of Urgent Care Claim
   Appeals of adverse benefit determinations involving Urgent Care claims may be submitted orally by telephone, in writing, facsimile or any other

   expeditious manner, so long as all information necessary to review the appeal is provided.

2. Time Limits for Deciding Appeal

   - **An Urgent Care Claim** will generally be decided within 72 hours of appeal.

- **A Pre-Service Claim** will generally be decided within 30 days of appeal.

- **A Post-Service Claim** will generally be decided at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal, unless the appeal arrives within 30 days of the next regularly scheduled meeting of the Board of Trustees, in which case it will be reviewed and decided at the following meeting of the Board of Trustees.

If special circumstances require an extension of time for processing the appeal, you will be given a notice in writing by the Trust Fund Office prior to the beginning of the extension period, explaining the special circumstances requiring an extension of time and indicating the date by which the Trustees expect to render a final decision on the appeal. The Trust Fund Office will

notify you or your authorized representative of the Board of Trustees' decision in writing, not later than 5 days after the determination is made.

E. **Denial of Appeal**

If your appeal has been denied in whole or in part by the Board of Trustees, you will be advised by the Trust Fund Office in writing of the specific reason or reasons for the denial, including any specific Plan Provision upon which the denial is based. If your appeal is denied, you are entitled to have free of charge, all documents, records and other information relevant to your claim for benefits. You will also be advised of the Trust's Voluntary Appeals Procedures, if any, along with the information required in connection with such a Voluntary Appeal Procedure. If applicable, the notice will also include the specific rule, guideline, or protocol relied upon by the Board of Trustees in making the decision and will either include a copy of the document or will advise you that a copy is available free of charge. If the Board's decision is based either in whole or in part on a medical judgment, the notice will explain the basis for the judgment or will contain a statement that the explanation is available free of charge to you.

In the event an appeal is denied by the Board of Trustees, you will be entitled to review all relevant information relied upon by the Board of Trustees in deciding the appeal, as well as any document, record, or other information which was submitted, considered, or generated in the course of making the benefit determination, whether or not it was relied upon in deciding the appeal.

Note: The decision of the Board of Trustees, with respect to a request for reconsideration, shall be final and binding upon all parties, including you and any person acting on your behalf.

F. Right to Bring Civil Action if Appeal Denied

If you are dissatisfied with the final decision of the Board of Trustees, you have a right to bring a civil action under Section 502(a) of ERISA in either State or Federal Court. No action may be filed by any person against the Trust, the Trustees, or any of the Trustees' agents more than (2) – Year limitation after you are given written notice of the denial of an appeal by the Board of Trustees. Unless you are otherwise expressly advised in writing, the two-year limitation period shall not be extended, even if the Board of Trustees again considers the appeal after the initial denial. This two-year limitation shall apply to all legal and equitable actions arising out of, or relating to, a claim for benefits including, but not limited to, any legal or equitable action under ERISA to the extent the claim relates to the provision of benefits or rights under the Trust.

XIV. Plan Administration Information

A. Name of Plan

The name of the Plan is the Labor-Management Universal Health Benefits Trust. The Plan is administered by the Board of Trustees of the Labor-Management Universal Health Benefits Trust, pursuant to the terms of a Trust Agreement.

B. Name, Address, and Telephone Number of Board of Trustees

Labor-Management Universal Health Benefits Trust
c/o Trust Fund Office
1055 Park View Drive, Suite 111
Covina, California 91724
www.lmuhbt.com

Telephone: (800) 662-9265 · (562) 463-5005
Fax: (626) 279-3055

C. Tax Identification Number

The Taxpayer Identification Number assigned to the Trust by the Internal Revenue Service is 95-6975448.

D. **Plan Number**

The Plan Number assigned to this Plan is 501.

E. **Type of Plan**

The Plan is a group health plan that may provide any or all of the following benefits: Life and Accidental Death and Dismemberment Insurance, Medical, Dental, Drug, and Vision benefits.

F. **Type of Administration**

The Plan is administered by the Board of Trustees with the assistance of Pacific Southwest Administrators, a contract administrative manager.

G. **Name, Address, and Telephone Number of Administrative Office**

Labor-Management Universal Health Benefits Trust
c/o Trust Fund Office
Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724
www.lmuhbt.com

Telephone: (800) 662-9265 or (562) 463-5005
Fax: (626) 279-3055

H. **Name and Address of Agent for Service of Process**

The Board of Trustees has appointed its Administrator, Pacific Southwest Administrators, as its agent for service of process. The address is the same as given in item B above. Legal papers may also be served on any of the Trustees. The names and addresses of the Trustees are set forth in item (I) below.

I. **Names and Address of Trustees**

Union Trustees	Management Trustees
Robert Cox	Michele Keetin
Shig Cash Noguchi	Nick Silk

Labor-Management Universal Health Benefits Trust
c/o Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, California 91724
www.lmuhbt.com

J. Carriers and Providers of Service

The insurance carriers and providers of service for this Plan are—

1. Hospital, Medical And Surgical Benefits

   Kaiser Permanente (www.kaiserpermanente.org)

   Prepaid Medical Plan provided by Kaiser Permanente. Services that are prescribed or directed by a Kaiser Permanente physician are provided at specified co-payments. For your specific co-payment schedules and benefits, please contact the Trust Fund Office. Kaiser will provide you with a booklet describing its services.

   You must live within the service area (see separate booklet for description of service area) of any Kaiser medical facility in order to enroll in this option. If you enroll in this option, you and your enrolled Dependents must receive all care through Kaiser offices and hospitals.

   Health Net of California (www.healthnet.com)

   A Prepaid Medical Plan provided by Health Net of California. Services that are authorized by your Health Net physician are provided at specified co-payments. For your specific co-payment schedules and benefits, please contact the Trust Fund Office. Health Net will provide you with a booklet describing its services and benefits.

   You must live within the service area (see separate booklet for description of service area) of the facility you will be using in order to enroll in this option. If you enroll in this option, you and your enrolled Dependents must receive all care through the participating medical group or physician you have selected.

2. Dental Benefits (HMO and PPO)

   LIBERTY Dental Plan of California (www.libertydentalplan.com)

   A Prepaid Dental Plan provided by LIBERTY Dental Plan of California. Services that are authorized by your LIBERTY Dental Dentist are provided at specific co-payments depending on whether you choose the HMO or the PPO option. For your specific co-payment schedules and benefits,

please contact the Trust Fund Office. LIBERTY Dental Plan of California will provide you with a booklet describing its services and benefits depending on whether you choose the HMO or PPO option. If you are enrolled in the LIBERTY Dental HMO, you must receive all dental care through a LIBERTY Dental dentist.

3. Vision Benefits

   Vision Service Plan (www.vsp.com)

   Vision Service Plan (VSP) provides a Prepaid Vision Plan for participants that are eligible to receive such benefits. The Prepaid Vision Plan through VSP covers specific services at defined co-payment schedules. For your specific co-payment schedules and benefits, please contact the Trust Fund Office. VSP will provide you with a booklet describing its services and benefits.

4. Life Insurance And Accidental Death And Dismemberment Benefits

   The Hartford (www.thehartford.com)

   The Hartford underwrites life insurance and accidental death and dismemberment benefits for participants in the Plan who are eligible to receive such benefits.

   Please contact the Trust Fund Office for information concerning your specific benefits.

   Pacific Southwest Administrators
   1055 Park View Drive, Suite 111
   Covina, California 91724
   www.lmuhbt.com

   Telephone: (800) 662-9265 · (562) 463-5005
   Fax: (626) 279-3055

K. Description of Collective Bargaining Agreements

The Trust and its benefit plans are funded primarily from employer contributions. Employers make contributions for bargaining unit employees, as required by the terms of various Collective Bargaining Agreements. Generally, the Collective Bargaining Agreements provide that the employer will make contributions at a specified rate per employee per month.

By signing special agreements, some employers may also make contributions for non-bargaining unit employees in the amounts comparable to what is paid for bargaining unit employees. Copies of the applicable Collective Bargaining Agreements will be furnished by the Trustees, upon written request addressed to the Trust Fund Office.

The Trustees may impose a reasonable charge for these copies. Copies are also available for examination at the Trust Fund Office, upon 10 days advance written request. Copies are also available at the Union Office.

L. Participation, Eligibility and Benefits

For a summary of the Trust provisions concerning Participation and Eligibility, see previous sections. Benefits are summarized in booklets provided by the insurance carriers listed above with whom the Trust has contracted. If you need a copy of the carrier booklet that pertains to your benefits, you may contact either the Trust Fund Office or the carrier directly at the contact information listed above.

M. Circumstances Which May Result in Disqualification, Ineligibility, or Denial of Benefits

A participant or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

1. The employee's failure to work the required hours to maintain eligibility or failure to make a COBRA self-payment, where authorized. (See Eligibility Section of this booklet).

2. The failure of the participant's employer to report the hours and remit contributions on his or her behalf to the Trust.

3. In case of beneficiaries who are dependents of an Eligible Employee, they may become ineligible if—

    a. they are no longer dependents or
    b. they have attained the disqualifying age.

    (See Dependent rules set forth in Eligibility Section of this booklet.)

4. Failure of a participant's employer to sign an agreement with a participating labor organization.

5. The possible modification or termination of Plan benefits due to financial circumstances requiring the Trustees to take such action.

A participant or beneficiary who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

1. The failure of the employee or beneficiary to file a claim for benefits within the required time.

   The health care providers and/or dental providers providing coverage under the Trust require that claims for reimbursement be filed within 60 days of service.

   All other benefits require written proof of loss 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.

2. The failure of the employee or beneficiary to file a complete and truthful benefit application.

3. Where the employee or beneficiary has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two Plans.

4. Where the loss for which claim is being made is subject to an exclusion or limitation of the insurance policy or health plan agreement.

5. The possible modification or termination of Plan benefits due to financial circumstances requiring the Trustees to take such action.

N. Compliance with ERISA

The Trustees believe that the benefit plans offered by the Trust are fully compliant with the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. Any omissions or oversights will be resolved in accordance with ERISA.

O. Source of Contributions

All contributions are made primarily by the participating employers. Employee self-payments are allowed under COBRA Continuation Coverage. A complete list of participating employers and labor organizations may be obtained by participants and beneficiaries upon written request to the Trust Fund Office and is available for examination upon 10 days advance written notice at the

Trust Fund Office. The Trustees may impose a reasonable charge for the list of participating employers.

Contributions to the Trust for the purpose of providing benefits to eligible individuals are made by the employer on a month-to-month basis according to a Collective Bargaining Agreement. Such contributions are supplemented by COBRA self-payment participants and beneficiaries.

Should contributions under the Collective Bargaining Agreements and COBRA self-payments (if any) not provide sufficient funding to maintain the present benefits, the Trustees reserve the right to increase the contribution rate, change the eligibility rules, reduce the benefits, or eliminate plans of benefits entirely, as may be required by the circumstances.

P. **Plan Year**

The plan year for this Plan ends on December 31 of each year. Each 12-month period commencing on January 1 consists of an entire plan year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

Q. **Procedure To Be Followed in Presenting Claims for Benefits and Remedies Available for Redress of Claims Which Are Denied**

There are detailed procedures for presenting applications for benefits. Please refer to the section or booklet describing the plan under which you are enrolled and how to file a claim for benefits. For details about each provider's claims appeal and review procedures, please refer to that provider's Evidence of Coverage booklet or contact that provider directly.

You may obtain an Evidence of Coverage booklet and relevant policies free of charge from the Trust Fund Office. A list of contact information for the companies providing benefits through this Trust may be found above in the section entitled "Carriers and Providers of Service."

Note: Most if not all applications or claims for benefits should be made directly to the benefits provider or insurer. In the rare instance that your claim or application needs to be presented to the Trust Fund Office or the Board of Trustees, Section XIII of this booklet describes procedures for presenting such a claim or application for benefits.

R. Trustee Determinations Conclusive

The Board of Trustees shall have full discretion and authority to make any findings of fact or law needed in the administration of the Trust and shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion they deem to be appropriate in their sole judgment. The determinations of the Board shall be conclusive and binding as to all persons and for all purposes. All determinations and decisions made by the Board of Trustees in connection with the Trust shall be made in their sole discretion even when the Trust does not explicitly so state, except to the extent that the retention of discretion is prohibited by ERISA.

To the extent the Board of Trustees has been granted discretionary authority under the Trust, the Board's prior exercise of such authority shall not obligate it to exercise its authority in a like fashion thereafter.

If the validity of the Board's exercise of discretion, finding of fact or of law, interpretation, construction, or decision is challenged in court, by arbitration, or in any other forum, it shall be upheld unless clearly arbitrary or capricious.

If, due to errors in drafting, any Trust provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Board in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Board in a fashion consistent with its intent, as determined by the Board in its sole discretion. The Board shall amend the Trust retroactively to cure any such ambiguity.

This Section may not be invoked by any person to require the Trust to be interpreted in a manner that is inconsistent with its interpretation by the Board.

XV. Statement of ERISA Rights

As a participant covered under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan's Trust Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administration may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Trust Fund Office is required by law to furnish each Participant with a copy of this summary financial report.

- Continue health care coverage for participant, participant's Spouse or participant's Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. Participant or participant's Dependents may have to pay for such coverage. Review this Summary Plan Description/plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- To the extent permitted by the Affordable Care Act or the Health Care and Education Reconciliation Act of 2010, reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan.

A. **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Trust participants, ERISA imposes duties upon the people who are responsible for the operation of the Trust. The people who operate your Trust, called "fiduciaries" of the Trust, have a duty to do so prudently and in the interest of you and other Trust participants and beneficiaries. No one, including your employer, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

B. **Enforce Your Rights**

If your claim for a Trust benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights.

For instance,

- if you request a copy of Trust documents or the latest annual report from the Trust and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Trust Fund Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Fund Office.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Trust's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.
- If it should happen that Trust fiduciaries misuse the Trust's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.
- If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

C. **Assistance with Your Questions**

If you have any questions about your Trust, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, which is located at 1055 East Colorado Boulevard, Suite 200, Pasadena, CA 91106-2357. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

This Summary Plan Description is required by federal law. Of necessity, many of the substantive Trust Provisions mentioned in the Summary Plan Description have been set forth in summary or capsulate form. It is not to be considered the contract of insurance. All statements made in this booklet are subject to the complete terms of the coverages as set forth in the Master Service Agreements issued by the providers and/or insurance companies, and all amendments to those respective documents. Please refer to the master policies and agreements for a complete and detailed description of the coverages.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Trust or Plan

administration, should be referred to the Trust Fund Office at the following address and telephone numbers:

Labor-Management Universal Health Benefits Trust
1055 Park View Drive, Suite 111
Covina, California 91724
www.lmuhbt.com

Telephone: (800) 662-9265 or (562) 463-5005
Fax: (626) 279-3055

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