CALIFORNIA SMALL MANUFACTURING

HEALTH & WELFARE TRUST FUND

WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective October 1, 2022

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ALERT

The benefits provided under the California Small Manufacturing Health & Welfare Trust Fund Welfare Benefit Plan may be changed at any time. The Board of Trustees may reduce or eliminate any benefits and may change or eliminate insurance carriers or HMOs.

The benefits summarized in this Summary Plan Description are as of the date prepared. Any subsequent amendments will govern the actual benefits payable.

This booklet, known as a Summary Plan Description (SPD), contains general information regarding your benefits under the plan and an explanation of the plan's eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your plan. Please direct any questions you have to the Administration Office at 833-648-2089.

Please remember that this booklet is only a summary that provides a brief description of the plan – it does not fully describe or summarize the provisions and operation of all of the benefits that may be provided through the plan. It must be read in conjunction with the benefit summaries, evidence of coverage booklets, annual enrollment materials, and other summary materials provided to you by the Plan Administrator or the insurance company(ies). If you have questions or need copies of such materials, please contact the Plan Administrator.

The Plan Administrator has a copy of the official plan document for the plan, as it may be modified from time to time, that is readily available for your inspection. If you have questions or need a copy of the plan, please contact the Plan Administrator.

If there is ever any conflict between the plan document and any statements made in this SPD, the plan document will control. If there is ever any conflict between an insurance policy providing benefits under the plan and either the plan document or this SPD, the insurance policy will control (unless otherwise required by applicable law). No statements contained in this SPD or any summary of material modifications to this SPD constitute terms of the plan – all such terms are contained in the plan document and any duly authorized and adopted amendments to the plan document. Please remember that no employee of your employer – not even your supervisor – has any authority to bind the plan to any benefit or procedure that conflicts with the insurance policy(ies), the official plan document, or this SPD.

Only the full Board of Trustees (Board) is authorized to interpret the plan. The Board has the discretionary authority to decide all questions about the plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the plan. No individual trustee or employer has authority to interpret this plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

Open enrollment is held annually in a month determined by the Board. During open enrollment you can elect to change your benefit plan options selection by completing a new enrollment card through the Administration Office. Your change must be received by the Administration Office by the designated open enrollment deadline to be effective the next plan year. Provider benefit booklets are available at the Administration Office.

The Board has authorized the Administration Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Administration Office for a definitive answer. The Administration Office is located at:

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

Plan rules and benefits may change from time to time. The plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

The Board of Trustees

IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the plan rules. You should review the plan to fully determine your rights.

You are not entitled to rely upon oral statements of employees of the Administration Office, a trustee, an employer, or any other person or entity.

As a courtesy to you, the Administration Office may respond orally to questions; however, oral information and answers are not binding upon the plan and cannot be relied upon in any dispute concerning your benefits.

If you would like an interpretation of the plan, you should address your request in writing to the Board at the Administration Office. **To make their decision, the Board must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible dependents and/or claims.**

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon audit or review. **The Board reserves the right to make corrections whenever any error or overpayment is discovered.**

NO VESTED RIGHTS

Benefits under this plan are NOT vested. The Board may amend, reduce, eliminate or otherwise change the plan at any time and may change, reduce, or discontinue any plan benefits, in whole or in part, at any time. Moreover, the Board may require new or greater premiums, copayments, or deductibles at any time. The Board may change the eligibility requirements and any other plan rules at any time.

USE OF MASCULINE GENDER WORDS

In all situations, whenever any words are used in the plan in the masculine gender, they should be construed as though they were also used in the feminine gender where they would so apply.

I. ELIGIBILITY REQUIREMENTS

A. Eligibility For Benefits

You will become eligible for benefits under this plan the first day of the month after you have satisfied the eligibility and waiting period required by your employer in its Adoption Agreement and your employer makes monthly contributions to the Trust Fund on your behalf for your coverage.

B. Enrollment

When you first become eligible, you **MUST** complete the Trust Fund's Enrollment/Beneficiary form(s) and any applications required by the Trust Fund or the insurance carrier(s) or HMO(s). These may be paper forms, electronic forms, or both. Your failure to properly complete and execute the enrollment form(s) and application(s) will delay the effective date of your health coverage. These documents will be sent to you by the Administration Office or its representative (e.g., an electronic enrollment service). If you do not receive these documents, you can contact the Administration Office:

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

C. Covered Dependents

Your covered dependents are your lawful spouse (husband or wife), natural children, legally adopted children and stepchildren.

The rules for a dependent child are:

1 Blood Descendent: A blood descendent of the first degree.
2 Adopted Child: A legally adopted child, including children living with adopting parents during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption.
3 Guardianship: A child for whom you are appointed the legal guardian.
4 Adding Dependents: During the period you continue to have coverage, any new eligible dependents you acquire may be added in accord with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the plan. Whenever you acquire a new dependent, you must complete an updated enrollment card within 31 days.
5 Covered dependents are eligible for all benefits provided from birth through the age of 25 years.

No dependent can ever be deemed a covered dependent unless he or she is a dependent of a participant.

IMPORTANT NOTICE:
WARNING ABOUT FRAUD AGAINST PLAN
It is the participant's and dependent's responsibility to notify the Administration Office immediately when a dependent's status changes. This includes divorce/final dissolution of marriage, legal separation, death, a dependent child over age 25, and any other events which would make your dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any dependent and it is later found that the dependent was not eligible, you and the dependent will be responsible for reimbursing the plan for the actual amount paid out in benefits by the trust plus interest and any costs and attorney's fees incurred to recover the money.

D. Domestic Partners

A covered participant's domestic partner will be covered if the domestic partnership meets the following criteria:

1 Both persons must file a Declaration of Domestic Partnership with the Secretary of the State of California;

2 Both persons must have a common residence;

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

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

5 Both persons must be at least 18 years old;

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

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

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

The election by a covered participant to add a domestic partner may have certain federal income tax implications. Under federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the participant. (Please note that domestic partner benefits are not taxable under California law.)

E. Automatic Coverage for a Newborn Child-If Plan Notified Within 31 Days

Your newborn child is covered from the date he/she is born. Within 31 days after the child is born, you must inform the Administration Office of the child's birth and agree to pay any required contributions toward the cost of the child's coverage. Otherwise, coverage for the child will cease at the end of the 31 day period. If you acquire a new qualified dependent while your

coverage for the other dependents is in effect, you must agree to pay any required increase in contribution within 31 days of acquiring the new dependent for that dependent to become covered.

If you are required to contribute toward the cost of insurance and if the child's coverage terminates because you fail to apply (or pay the required contribution) within the 31-day period, no benefits will be payable. The individual purchase rights and the extended benefits (after termination of coverage) will not apply to the child.

F. Qualified Medical Child Support Orders (QMSCO)

The participant must timely provide the Administration Office with a copy of any court order that establishes the participant's legal obligation to maintain coverage on a dependent child including a QMCSO.

A QMCSO recognizes an eligible child's right to receive plan benefits as a beneficiary of an eligible plan participant. The child, to be covered for benefits by this plan, must meet plan requirements for an eligible dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

1 The participant must provide the Administration Office with a copy of the court order and/or QMCSO.

2 Within thirty (30) days after receipt of the QMCSO, the Administration Office or the plan's legal counsel will notify the participant in writing if the court order and/or QMCSO is acceptable to the plan.

3 If the plan determines that the court order and/or QMCSO is not acceptable, or if additional information is required, the participant will be notified in writing by the plan or the plan's legal counsel.

a) **If a QMCSO is denied**. The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO.

b) **If additional information is required**. The notice will describe what is needed. There will be 60 days to respond. If you do not respond within the 60 days, the request for the QMCSO will be deemed canceled.

Please be aware that if a child covered under a QMCSO was enrolled independent of the participant neither the participant nor any other dependents would be considered enrolled in the plan until such time as the participant has completed all enrollment procedures.

II. TERMINATION OF COVERAGE

Your personal, dependent and/or domestic partner coverage will cease on one of the following dates, whichever occurs first:

- the date you no longer meet eligibility requirements for coverage under the Adoption Agreement signed by your employer;

- the date at the end of the last period for which you made any required contribution toward the cost of that coverage;

- the date any one dependent ceases to be your qualified dependent or the date your domestic partnership is terminated;

- Failure of your employer to pay contributions on your behalf.

III. CONTINUATION OF COVERAGE

A. Military Service-Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may purchase coverage for your dependents under the rules included in the COBRA section described in this SPD. You should notify the Administration Office in the event you enter military service for more than 30 days.

1 Participants who wish to elect continued coverage during a period of military service may obtain such coverage for a maximum of 24 months; however, the participant will be responsible for the premium for up to the 24 month continuation coverage at the plan's current COBRA premium rates.

2 The employer shall provide coverage through contributions to cover the employee whose military service is for less than 31 days.

3 The employer shall provide, through contributions, any seniority based benefits of the plan to which an employee is entitled due to the provisions of USERRA.

4 Upon discharge from uniformed service, an employee who is re-employed with a contributing employer in accordance with the provisions of USERRA shall be entitled to coverage under the plan, and all rights and benefits under the plan the participant would have attained if the participant had remained continuously employed with a contributing employer. The employee shall notify the Administration Office of his or her return to work for a contributing employer within 90 days of the date of the employee's honorable discharge from uniformed service.

NOTE: Participants and their dependents may be eligible for coverage under Tri-Care. The participants should review these coverages before making a decision to self-pay.

IV. BENEFITS

A. Medical Benefits

The Trust Fund provides medical benefits through fully insured arrangements with one or more insurance carriers (e.g., PPOs) and health maintenance organizations (HMOs). A separate booklet that describes these coverages is available from the insurance carrier(s) or HMO(s), or at the Administration Office. Each employer that participates in the Trust Fund selects the arrangement(s) that it will make available to its employees. You will receive notice of the options available to you when you first become eligible to participate in the plan and during each open enrollment period. In addition, you may contact the Administration Office to determine which options your employer has elected to offer to you.

For details on your benefit coverage, including the name and the address of the provider, please refer to the Evidence of Coverage Booklet that you receive from the provider.

B. Dental Benefits

The Trust Fund provides dental benefits through insured arrangements with one or more insurance carriers. A separate booklet is available at the Administration Office that describes these coverages. Each employer that participates in the Trust Fund selects the arrangement(s) that it will make available to its employees. You will receive notice of the options available to you when you first become eligible to participate in the plan and during each open enrollment period. In addition, you may contact the Administration Office to determine which options your employer has elected to offer to you.

For details on your benefit coverage, including the name and the address of the provider, please refer to the Evidence of Coverage Booklet that you receive from the provider.

C. Vision Benefits

The Trust Fund provides vision benefits through insured arrangements with one or more insurance carriers. A separate booklet is available at the Administration Office that describes these coverages. Each employer that participates in the Trust Fund selects the arrangement(s) that it will make available to its employees. You will receive notice of the options available to you when you first become eligible to participate in the plan and during each open enrollment period. In addition, you may contact the Administration Office to determine which options your employer has elected to offer to you.

For details on your benefit coverage, including the name and the address of the provider, please refer to the Evidence of Coverage Booklet that you receive from the provider..

D. Voluntary Benefits

The Trust Fund provides voluntary group insurance benefits (e.g., basic life/AD&D, voluntary life/AD&D, long-term disability, short-term disability, accident, critical illness, or hospital indemnity) through insured arrangements with one or more insurance carriers. A separate booklet is available at the Administration Office that describes these coverages. Each employer that participates in the Trust Fund selects the arrangement(s) that it will make available to its

employees. You will receive notice of the options available to you when you first become eligible to participate in the plan and during each open enrollment period. In addition, you may contact the Administration Office to determine which options your employer has elected to offer to you.

For details on your benefit coverage, including the name and the address of the provider, please refer to the Evidence of Coverage Booklet that you receive from the provider.

V. COBRA

IF YOUR COVERAGE ENDS BECAUSE OF:	***COVERAGE MAY CONTINUE FOR UP TO:***
Termination of employee's employment (for any reason other than gross misconduct) or reduction in employee's work hours	18 calendar months (29 calendar months if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the employee or his or her dependent is totally disabled (as determined by Social Security)). Under CAL-COBRA, members receive an additional 18 calendar months
Death of employee, divorce or legal separation of employee or spouse, cessation of domestic partnership, dependent child no longer qualifies for dependent coverage under the plan	36 calendar months for dependents

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that covered employees and dependents be allowed to continue their medical coverage at their own expense following certain qualifying events that result in a loss of coverage. The premium is 102% of the cost of coverage.

1. Termination of Employment or Reduction in Hours

If your employment terminates or your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended. Under CAL-COBRA, members may elect to receive an additional 18 months coverage.

2. Disability-Extended Coverage

If you or an eligible dependent is determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18-month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11-month extension. The premium for the additional 11 months of extended coverage is 150% of the cost of that coverage.

To be eligible for the special 11-month extension, the disabled individual must notify the plan

within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial 18-month period of COBRA continuation coverage.

3. Dependent/Domestic Partner COBRA Coverage

Children born to you or placed with you for adoption during your continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage, you must promptly notify the Administration Office at the time of birth or placement for purposes of adoption.

If you first become entitled to Medicare while on COBRA coverage which was elected following a termination of employment or a reduction in hours, your eligible dependents may elect to extend their initial 18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents or your domestic partner loses coverage due to your death, your surviving spouse, domestic partner and/or other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that child may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse/domestic partner ceases to be an eligible dependent because of a divorce, legal separation or termination of the domestic partner relationship, your former spouse/domestic partner may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's/domestic partner's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect to continue coverage for dependent children. An employee electing COBRA continuation coverage may elect to continue coverage for the employee's lawful spouse.

4. Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage. The COBRA continuation coverage premiums are adjusted annually by the Trust Fund and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage.

5. Termination of COBRA Coverage

COBRA continuation coverage terminates on the earliest of the following events:

a) The last day of the period for which COBRA continuation coverage may be elected.

b) The date a required COBRA premium payment is due and not received by the Administration Office.

c) The date the plan is terminated.

d) The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan that does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different employees of the same family.

e) The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage.

f) For individuals who are receiving the special 11-month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled.

If your coverage ends because of termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Administration Office within 60 days of the date of loss of coverage. The Administration Office or specified service provider will then transmit a notice of COBRA continuation rights and an application related to the coverage.

If your coverage ends for any other reason (for example, 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 Administration Office in writing within 60 days after the qualifying event occurs. The Administration Office or specified service provider will then transmit a notice of COBRA continuation rights and an application related to the coverage. Your failure to give such notice within the 60-day period will result in the loss of the right to elect to continue coverage under the plan.

The materials transmitted by the plan will explain your available options. The materials transmitted will also explain the application process and the premium rates applicable to coverages elected.

6. Election of COBRA Coverage

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

At the end of the COBRA continuation period elected, you may be allowed to either continue coverage under Cal-COBRA or enroll in an individual conversion health plan provided to the Trust Fund by certain service providers (such as an HMO or insurance company). Information related to Cal COBRA and individual conversion health plans may be obtained from the Administration Office or the specified service provider.

If you or your spouse or dependent have COBRA continuation coverage through the an HMO

program and you are terminated from the program because you move out of the HMO's service area before the applicable COBRA period expires and the Trust Fund does not have a contract with your HMO in that area, your COBRA coverage will cease. Please call the Administration Office for additional details.

In order to assure receipt of COBRA materials and other announcements describing changes in the plan, you and your dependents should advise the Administration Office of any and all changes in your address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Administration Office or specified service provider in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. If you fail to timely pay your COBRA premium, you will immediately lose your coverage.

VI. FAMILY AND MEDICAL LEAVE ACT

The federal Family and Medical Leave Act (FMLA) provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

Certain employers must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1 Your employer has at least 50 employees;

2 You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3 You require leave for one of the following reasons:

a) Birth or placement of a child for adoption or foster care;

b) To care for your child, spouse or parent with a serious medical condition; or

c) Your own serious health condition.

Details concerning FMLA leave are available from your employer. Requests for FMLA leave must be directed to your employer; the Trust Fund cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If your employer continues your coverage during a FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Trust Fund for your coverage during this leave.

It is not the role of the trustees or the Administration Office, or the Plan Administrator to determine whether or not an individual employee is entitled to leave with continuing medical care under the applicable laws. Disputes as to the entitlement to leave with continuing medical

benefits must be resolved by the employer and the employee.

To the extent that participants are entitled to leave with continuing medical coverage pursuant to federal and State law, the Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer.

VII. FEDERAL NOTICES

A. Newborns' and Mothers' Health Protection Act of 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the medical plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accordance with federal law, those plans do not require that a provider obtain preauthorization for either of the foregoing lengths of stay. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

B. Women's Health and Cancer Rights Act of 1998

Your plan covers medical and surgical benefits for mastectomies. This coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the plan's annual deductibles and coinsurance provisions.

C. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the insurance carrier(s), HMO(s), or the Trust Fund provide written certification of creditable coverage to you when your coverage ceases (under employer coverage or COBRA coverage), or when requested by you if your coverage is still in effect, or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Trust Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Trust Fund in writing at the following address:

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

You (or someone on your behalf) should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Trust Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Trust Fund send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

Special Enrollment Rights

Under HIPAA you are entitled to special enrollment rights if you acquire a new dependent or you and your dependents were covered under your spouse's plan and you lose coverage under your spouse's plan. However, you must request enrollment within 31 days after you acquire a new dependent or your coverage under your spouse's plan ends,

D. HIPAA Special Enrollment Rights under SCHIP

You and your dependents may enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (SCHIP)**.** However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

E. 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 HIPAA.

PHI is defined as individually identifiable health information that is maintained or transmitted by this plan 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, employer, health care clearinghouse or this plan and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for the provision of health care. When held by this plan, it also means information that either 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.

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

1. Permitted Uses and Disclosures of PHI

This plan and its business associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. 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 and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

This plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of 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 HIPAA.

3. Agreed to Uses and Disclosures of PHI by You after an Opportunity to Agree or Disagree to the Disclosure

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

4. 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, worker's compensation programs and correctional facilities. 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 Administration Office.

5. Your Individual Rights

HIPAA affords you the following rights:

- 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. 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.

- 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 a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

- 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 request form to access PHI in a designated record set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this plan is unable to comply with the deadline. This plan may charge a reasonable fee for the costs of copying. 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 the HHS or its OCR.

- 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 request form to amend 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. If the request is denied in whole or in part, the plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

- 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 the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about

your own PHI. Also, this plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date under HIPAA. You will be required to complete a request form to obtain an accounting of PHI 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 account 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. 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 HIPAA, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding 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.

7. This Plan's Duties

In accordance with HIPAA, only certain employees may be given access to your PHI. The Administration Office has designated this group of employees to include all employees dealing with the Trust. 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 HIPAA.

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.

This plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. 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, and uses or disclosures that are required for this plan's compliance with HIPAA's administration simplification rules.

8. 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, such as your name and Social Security Number.

This plan may disclose summary health information to the Board or a business associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with HIPAA.

This plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. However, this plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

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

10. 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, Vanessa Jones, at the following address:

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

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.

11. Security Standards Under HIPAA

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

VIII. GENERAL PROVISIONS

1. Coordination of Benefits

General Coordination of Benefits Rule: If a covered participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

2. Benefit Continuation

It is the intent of the Board to continue this plan indefinitely, although the Board reserves the right to modify or discontinue this coverage at any time. Thus, benefits may be reduced or eliminated entirely. Moreover, participants could be asked to pay a portion or all of the required premiums.

3. Exclusion for Fraud

No benefits are paid for fraudulent claims or services or supplies by a covered participant, eligible dependent or any other person. If a fraudulent claim has been paid by the plan or by any entity on behalf of the plan for any person, both the participant and any person on whose behalf a fraudulent claim was submitted or paid is liable to the plan for repayment of benefits paid and the amount of any premium paid to an HMO, PPO, insurance company or any other entity. This does not preclude the plan, HMO, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits, services or supplies, including reimbursement for any attorney's fees and costs incurred to recover such amounts.

By way of example, if a participant improperly signs up a person as a dependent who is not lawfully a dependent under the plan, both the participant and such unlawful dependent will be

liable to the plan and the plan's providers for any claims paid, any premium paid by the plan, and any attorneys fees and costs incurred by the plan and any provider in recovering such improperly paid claims.

4. Source of Financing of the Plan

The plan is funded by payments made to the Trust Fund by employers who are participating in the Trust Fund pursuant to an Adoption Agreement. The plan is also funded by employee contributions from employees whose employer's Adoption Agreement requires employees to pay a portion or all of the required contributions.

5. Disclaimer

The Trust Fund has established the current plan for the exclusive benefit of eligible participants, their dependents and domestic partners. The plan is intended to be maintained for an indefinite period of time. The plan, however, may be amended by the Board from time to time as to both eligibility requirements, benefit structures and selection of service providers as may be deemed necessary. The Board further reserves the right to terminate the plan should contributions from contributing employers become insufficient to provide benefits.

6. Not in Lieu of Workers' Compensation

The plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

7. Eligibility Issues

Eligibility for plan coverage is explained in this document under the section entitled "Eligibility."

The Administration Office is responsible for maintaining records regarding eligibility. Each month the Administration Office provides all benefit providers to the Trust Fund with a listing of eligible participants. There may be instances where a plan participant has a claim denied because he or she has not met the plan rules to be eligible for benefits under the plan. There are many reasons why this can happen. For illustrative purposes several examples are cited below:
Example 1: A participant may not work the required hours to be eligible for benefits as explained in his employer's Adoption Agreement.

> Example 2: A participant has worked the required hours in covered employment but his or her employer has not remitted the required contributions to the plan.
>
> Example 3: A participant is no longer working and the participant has elected COBRA continuation coverage, but he or she has failed to make the required self-payment to be eligible for continuation coverage.

Most eligibility issues are resolved quickly with a call or a letter to the Administration Office. The Administration Office is there to assist you and provide you with exact information on the status of your eligibility and entitlement to benefits under the various plans.

If you have a claim denied because you do not meet the eligibility requirements of the plan, you

have the right to appeal this denial. Your appeal should be in writing, and be sent to the Administration Office. You should state in your appeal why you believe you meet the eligibility requirements and provide any factual information you believe is important in having your appeal reviewed.

8. Appeal Procedures

The following describes the process to appeal actions of the Administration Office with regard to the Trust Fund's eligibility provisions, type or duration of benefits and any action of the Board. The appeals procedure does not apply to benefits obtained through HMOs, PPOs or any insured benefits.

a. No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the plan other than as specified in policies or contract procured by the Board or in the rules and regulations of the Board, or any right to claim to payments from the fund, other than as specified herein.

   Any dispute as to eligibility, type or duration of benefits, shall be resolved by the Board under and pursuant to the plan except that any dispute as to type or amount of benefits which are provided pursuant to a contract of insurance or service contract entered into by the Board shall be resolved under the terms of such contract.

   The Board shall have full discretionary authority to decide all other matters and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review. No action may be brought to enforce any right under the plan until a claim therefore has been submitted to and determined by the Board and thereafter the only action which may be brought is one to enforce the decision of the Board or to clarify the rights of the claimant under such decision.

b. Any person whose application has been denied in whole or in part by the Board shall be notified of such decision in writing by the Board and may petition the Board to reconsider its decision. A petition for reconsideration shall be in writing, shall state in clear and concise terms the reason for disagreement with the decision of the Board and shall be filed with or received by the Administration Office within 180 days after the date shown on the notice to the petitioner of the decision of the Board.

c. Upon good cause shown, the Board may permit the petition to be amended or supplemented. The failure to file a petition for reconsideration within such 180-day period shall constitute a waiver of the claimant's right to reconsideration of the decision. Such failure shall not, however, preclude the applicant or claimant from establishing his or her entitlement at a later date based on additional information and evidence, which was not available to him or her at the time of the decision of the Board.

d. Upon receipt of a petition for reconsideration, the Board, a committee or an agent appointed by the Board and authorized to act on such petitions shall grant a hearing on the petition and receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence.

A decision by the Board shall be made no later than the date of the quarterly meeting of the Board that immediately follows the Administration Office's receipt of the request for reconsideration unless the request for reconsideration is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Administration Office's receipt of the request for reconsideration. If special circumstances require a further extension of time for processing, a benefit determination will be rendered no later than the third meeting following the Administration Office's receipt of the request for reconsideration and the Administration Office will provide you with a written notice of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Administration Office will notify you of the benefit determination as soon as possible but not later than 5 days after the benefit determination is made.

e. The decision of the Board with respect to petition for reconsideration shall be final and binding upon all parties, including the petitioner and any person claiming under the petitioner.

f. No action may be brought to enforce any rights under the Trust Fund or the plan until after the claim therefore has been submitted and determined by the Board and, thereafter, the only action that may be brought is one to enforce the decision of the Board.

g. Any dispute as to the type or level of benefits provided under a contract of insurance or a service contract entered into by the Board shall be resolved in accordance with the terms of such contract including any appeals provisions of such contract.

Finality of Decision on Claim – Right to File Lawsuit

The denial of an application or claim after the right to review has been waived or the decision of the Board on appeal has been issued is final and binding upon all parties, including the claimant.

No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the plan or any trustee or legal fiduciary, person or entity involved in the decision more than two years after a claim has been denied on appeal.

When a Lawsuit May Be Started

No participant, dependent, beneficiary or other person shall have any right or claim to benefits under these rules and regulations or any right or claim to payments from the Trust Fund, other than as specified herein. A participant may not start a lawsuit to obtain benefits until after either: (1) the participant has submitted a claim pursuant to these rules and regulations, requested a review after an adverse benefit determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since participant filed a request for review and participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more than three years after services were provided or benefits partially of totally denied or an otherwise adverse determination was made against you.

The provisions of this section shall apply to and include any and every claim to benefits from the Trust Fund, and any claim or right asserted under the plan or against the Trust Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan, and shall not include any claim or right to damages, either compensatory or punitive.

9. Decision by Trustees

Under the plan and the Trust Agreement creating the Trust Fund, the Board or persons acting for the Board, such as a claims appeal committee, have sole authority to make final determinations regarding any eligibility issues, application for benefits and the interpretation of the plan, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Board. Decision of the Board (or, where appropriate, decision of those acting for the Board) in such matters are final and binding on all persons dealing with the plan or claiming a benefit from the plan. If a decision of the Board or those acting for the Board is challenged in court, it is the intention of the parties to the Trust Agreement that such decision is to be upheld unless it is determined to be arbitrary or capricious.

10. Relations Between Plan and Health Care Providers

No health care provider is an agent or representative of the plan or the Board. The plan does not control or direct the provision of health care services and/or supplies to participants and beneficiaries by anyone. The plan makes no representation or guarantee of any kind that any provider will furnish health care service or supplies that are malpractice-free. This statement also applies to all entities (and their agents, employees, and representatives) that contract with the plan to offer health related services or supplies to participants and beneficiaries. Nothing in this plan affects the ability of any provider to disclose alternative treatment options to a participant or beneficiary.

11. HMO, PPO and Insured Benefits Appeals

Benefits provided by an HMO, PPO, or through insurance are subject to the claims and appeal rules established by the HMO,PPO and insurance companies. You should contact the provider directly for its claim review or grievance procedure. The Administration Office can provide you with information on where to write.

12. Exhaustion of the Appeal Process

Under the federal law known as ERISA, a participant or beneficiary whose claim for benefits has been denied may file suit against the plan seeking the denied benefit. However, prior to filing such a suit, the appeal process under the plan described above must be pursued and exhausted. Thus, following any initial denial of benefits, if you disagree it is important that you file a timely appeal. In all cases your appeal must be filed no later than 180 days after the initial denial of your claim as received by you. If you do not file an appeal within the required time frame, you will have failed to exhaust your appeal rights. The Board may extend the 180 day limit upon

your showing good cause for the delay, but to protect your rights you should file any appeal promptly after you receipt of the initial denial.

13. Miscellaneous Provisions

The benefits payable hereunder shall not be subject to any manner of anticipations, alienation, sale or transfer.

No participant, dependent or other beneficiary shall have any right to claim to benefits from the plan, except as specified. Any dispute as to eligibility, type, or duration of the benefits under this plan or any amendment or modification thereof shall be resolved by the Board. The Board shall have discretion in any such determination. Participants may seek review of any adverse decision of the Board in federal district court as prescribed by law.

The benefits provided by the plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.

IX. POTENTIAL LOSS OF BENEFITS

You and/or your eligible dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

1. Inadequate or Improper Evidence

The plan grants the Board the power to deny, suspend or discontinue benefits to a participant who fails to submit at the request of the Administration Office any information or proof of coverage reasonably required to administer the plan.

2. Subrogation Third Party Claims

The plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

3. Coordination of Benefits

If dependents are covered by more than one plan, this plan may not be responsible for any claims.

4. Work-Related Injuries

The plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

5. Right to Recover Claims Paid or Offset of Future Claims

The plan has the right to recover any amounts improperly paid. The plan may offset any amounts owed to the plan against any claims that you and/or a dependent incur in the future.

6. Exclusions/Co-Payments

The HMOs, PPOs and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the HMOs, PPOs and the insurance provider's limitations, exclusions, copayments.

7. Failure to Complete Application

Benefits may not be payable until a completed application and other forms required by the Administration Office are received by the Administration Office.

8. Incomplete Information/False Statements

If you fail to provide requested information or give false information to verify age, beneficiary information, marital status or other vital information, coverage under the plan or benefits provided may be postponed or cancelled.

If you make a false statement to the plan or other officials regarding the payment of benefits or other issues related to the plan, you will be liable to the plan for any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Trust Fund, the Administration Office, reasonable attorneys' fees, and interest charges. The plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

9. Plan Termination

If the plan terminates, benefits will no longer be provided.

X. ERISA REQUIRED INFORMATION

1. **Name and Address of the Plan**: California Small Manufacturing Health & Welfare Trust Fund Welfare Benefit Plan, c/o Risk Program Administrators, 333 East Osborn Road Suite 300, Phoenix, AZ 85012, 833-648-2089.

2. **Type of Plan**: This is a health care plan, providing the following health care benefits – hospital, surgical, medical, dental and vision coverage.

3. **Type of Administration and Method of Trust Fund Benefits**: This plan is administered by a Board. The plan is funded by employer and/or employee contributions as provided for in each employer's Adoption Agreement.

4. **Sponsoring Organizations**: The plan is sponsored by the California Metals Coalition.

5. **Contributions**: Contributions to provide plan benefits are paid by the employers in accordance with their Adoption Agreements.

6. **Appeal Procedure**: The procedure for filing appeal denials is set forth above and in the separate booklets furnished by the insurance companies and other entities.

7. **Fiscal Year**: The fiscal year of the Trust Fund is the twelve-month period ending each

December 31, and the Trust Fund's records are maintained on that basis.

8. **Employer Identification Number**: 61-1670591

9. **Plan Number**: 501

10. **ERISA Rights**: As a participant in 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 Administrator's office all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, Internal Revenue Service and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies of some of these documents.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report at no cost to the participant.

- Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer as follows:

- when you leave coverage under that plan, when you become entitled to elect COBRA continuation coverage;
- when your COBRA continuation coverage ceases;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan Administrator to provide the materials and pay you up to $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the plan, you may file suit in a State or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order or domestic relations order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you. You may find answers to your questions and a list of EBSA offices at www.dol.gov/ebsa/welcome.html.

11. Names and Address of the Board of Trustees:

Vic Anselmo
Tim Gallagher
Sage Scott
Bruce Stenslie

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

12. Plan Administrator:

The Board is the Employee Retirement income Security Act of 1974 (ERISA) "Plan Administrator." The Plan Administrator is responsible for the overall operation of the plan. The Plan Administrator has the right to make rules and decisions concerning the operation of the plan and the eligibility for benefits. The Plan Administrator has the discretionary authority to interpret the plan and to make benefit determinations, including, but not limited to, factual

determinations. Decisions, interpretations and determinations made by the Plan Administrator shall be afforded the maximum deference afforded by law.

The plan engaged a professional contract plan administrator to act as the plan's third party administrator:

California Small Manufacturing Health &Welfare Trust Fund
c/o Risk Program Administrators
333 East Osborn Road Suite 300
Phoenix, AZ 85012
833-648-2089

If you have questions about the plan, please contact the contract plan administrator or the Board.

13. Name and Address of Agent for Service of Legal Process:

Employee Benefits Law Group PC
11231 Gold Express Drive, Suite 108
Gold River, CA 95670

Service of legal process may also be made upon a trustee.

14. Providers:

All of the benefits provided under the plan are insured and underwritten by various insurance carriers and health maintenance organizations (HMOs). Administrative services in connection with these insured benefits, including payment of claims, are performed by the providers that provide such coverages to you. The Evidence Of Coverage Booklets that you receive from the providers give you detailed information about your benefits as well as the name and address of the provider. Should you have any questions for any of the providers, you should contact the provider directly.

Your employer has no obligation under this plan beyond the payment of the employer's share of the appropriate premiums for participating in the plan and the remittance of each eligible employee's share of such premiums, if any, to the extent that such premiums have been paid to the employer by the employee or withheld from the employee's wages. Similarly, the Board of Trustees and the Trust Fund have no obligation under this plan beyond the remittance of the portions of the premiums actually received from the employers that are payable to the providers. The employers, the Board of Trustees, the Trust Fund and the California Metals Coalition are not responsible for the payment of any benefits under the plan because all benefits under the plan are fully insured.