# HRA PLAN

# For

# Non-Medicare Eligible Alaska Retirees

## PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

## June 1, 2024

## (To Sunset December 31, 2030)

## INTRODUCTION

To Retirees and Eligible Dependents:

This Booklet and Summary Plan Description (SPD) summarizes Health Reimbursement Arrangement Plan for Non-Medicare Eligible Alaska Retirees (HRA Plan) provided to non-Medicare eligible retirees and their dependents who were formerly enrolled in the Alaska Carpenters Health and Welfare Plan as of May 2024. This HRA Plan is administered by the Southwest Carpenters Health and Welfare Trust (Trust) as of June 1, 2024.

This Booklet contains the HRA Plan's eligibility rules for benefits, a description of the available benefits, continuation rights, the claims and appeal procedures and other information. It also contains the Summary Plan Description information required by the Employee Retirement Income Security Act of 1974 (commonly known as ERISA) and other statutory information.

The Trust will provide benefits under this HRA Plan only to the extent that monies are currently available to pay for the costs of such benefits. Trust benefits are not guaranteed, and no individual has a vested right to Trust benefits. Pursuant to the terms of the underlying Trust Agreement, the Board of Trustees has the sole authority and discretion to interpret the SPD and HRA Plan, determine the Trust's benefits, the conditions of eligibility, and to make any changes to the HRA Plan, including termination of this HRA Plan.

Absent action by the Board of Trustees, this HRA Plan shall terminate December 31, 2030.

To the extent the SPD is inconsistent with the applicable laws or regulations, the HRA Plan will be administered consistent with the laws or regulations.

If you would like further information or assistance, please call or write the Trust Administrative Agent.

Sincerely,

Board of Trustees

## PLAN DESCRIPTION

This Plan Booklet and SPD is intended to explain the Health Reimbursement Arrangement Plan for Non-Medicare Eligible Alaska Retirees (HRA Plan) in a manner that you can easily understand. If you have any questions after reading this document, please contact Carpenters Southwest Administrative Corporation, the Trust Administrative Agent, at (800) 293-1370 or (213) 386-8590.

## I. THE PURPOSE OF THE PLAN

The HRA Plan is available to former bargaining unit employees (Retirees) and their Eligible Dependents who meet the eligibility requirements set forth below, enroll in the HRA Plan (or satisfy the eligibility requirements as of June 1, 2024, and are, thus, automatically enrolled) and otherwise comply with this HRA Plan document. Eligible Retirees may use the amounts allocated to their Retiree Accounts to reimburse health insurance premiums.

## II. DEFINITIONS

Following are definitions that will help you better understand this summary of the HRA Plan:

1. Account Balance means the amount available for reimbursement from the Retiree Account.

2. Benefit means any amount paid to a Retiree as reimbursement for health insurance premiums incurred by the Retiree or the Retiree's Eligible Dependent.

3. Claims Administrator means the individual or entity retained by the Plan from time to time to pay claims.

4. Effective Date means the date a Retiree becomes eligible to receive a Benefit under the HRA Plan.

5. Eligible Dependent is defined in Section V.2. below.

6. Eligible Health Expense means those premium expenses paid by the Retiree and his or her Eligible Dependents for health insurance coverage for the benefit of the Retiree and his or her Eligible Dependents, up to the amount of the monthly Account Balance.

7. Retiree means an individual who meets the eligibility criteria set forth in Section III below.

8. Retiree Account refers to the bookkeeping or notional account maintained by the HRA Plan's Claim Administrator in the name of a Retiree which reflects the monthly amount available for reimbursement by the Trust, pursuant to the terms of this Plan Booklet and SPD.

9. Trust means the Southwest Carpenters Health and Welfare Trust, as it may be amended from time to time. The HRA Plan is a plan offered by the Trust for Retirees as defined herein.

## III. ELIGIBILITY AND PARTICIPATION

You as a Retiree are eligible to participate in the HRA Plan if:

1. You are age 53 or older and retired, and must withdraw completely and refrain from any employment or activity in the building and construction industry wherever such employment or activity may be performed in the geographic area covered by the Trust, including, but

not limited to, no longer working for an employer that is contributing to the Trust ("Prohibited Employment"), and

2. As of May 2024, you were covered as a retiree or active participant in the Alaska Carpenter Health and Welfare Trust, and

3. You had at least 10 years of credited service in the Southern Alaska Carpenters Retirement Plan or the Alaska Carpenters Defined Contribution Plan or their successor plans, and

4. For at least 12 of the last 18 months immediately preceding your request for enrollment in this HRA Plan (unless automatically enrolled), you had health coverage in the Alaska Carpenters Health and Welfare Trust or the Southwest Carpenters Health and Welfare Trust, and

5. You are not currently receiving or eligible to receive Medicare benefits.

## IV. HRA BENEFITS

The Trust has established this HRA Plan to reimburse Retirees for monthly premium expenses incurred by them or their Eligible Dependent, to obtain health insurance coverage for the Retiree and his or her Eligible Dependent. This HRA Plan is funded by a limited pool of money which is held by the Trust. For each enrolled non-Medicare eligible Retiree, the Trust shall make available each month to each Retiree Account an amount determined by the Trust. The Board of Trustees shall determine the monthly amount to be available for reimbursement. As of June 1, 2024, the monthly amount available is as follows:

1. For Retirees and Eligible Dependents who were covered in the Alaska Carpenters Health and Welfare Trust as of May 2024, the monthly amount shall be $400 per person.

2. For Retirees and Eligible Dependents who enrolled in this HRA Plan after June 1, 2024, the monthly amount shall be $400 per person and shall be limited to a period of up to 36 months.

The Board of Trustees may also adjust the monthly amount available to you following notice to the Retirees.

Any unused HRA Account Balances in a Retiree's Account ***will not*** roll over from month-to-month or year-to-year. Unused HRA Account Balances will be forfeited back to the Trust at the end of the month. If you stop participating in the HRA Plan either through loss of eligibility, opting-out or by failing to enroll when and if required, any Account Balances remaining in your Retiree Account will be forfeited back to the Trust.

You can use your Account Balance to reimburse for health insurance premiums that are incurred by you and your Eligible Dependents on or after the date you first become eligible. Health insurance premiums are limited to premiums paid by the Retiree or the Retiree's Eligible Dependent to purchase individual health insurance coverage for the Retiree or Eligible Dependent, up to the monthly Account Balance. In no event will your monthly reimbursements exceed your monthly amount allowed by the Trust.

Your Retiree Account will cease when you become Medicare eligible, engage in Prohibited Employment or stop participating in the HRA Plan for any reason.

## V. BENEFIT REIMBURSEMENT RULES

### *1. What Expenses Can Be Reimbursed under the Plan?*

The HRA Plan will only reimburse health insurance premiums that are incurred on or after the first date the Trust makes a contribution to your Retiree Account. All claims must be submitted for reimbursement within 60 days of the date on which the health insurance premiums were incurred. During a participant's initial month of eligibility, premium payments incurred in the previous month shall be eligible for

reimbursement. For example, if a participant is first eligible in June 2024, premium payment made in May 2024 will be eligible for reimbursement in June 2024 and then June 2024 premium payment will be eligible for reimbursement in July 2024, etc.

Eligible Health Expenses are limited to those health insurance premiums paid by the Retiree or the Retiree's Eligible Dependent up to the maximum amount available for reimbursement.

Under no circumstance will an expense be reimbursed under this HRA Plan if the expense is provided, paid or payable by any other health or accident plan or insurance policy covering you or an Eligible Dependent (including Social Security, Medicare, Medicaid), or if you will be reimbursed for the expense from another source. Premiums for Medicare coverage and supplemental Medicare coverage plans or policies (commonly referred to as "Medigap policies"), are not eligible for reimbursement under the HRA. Benefits will always be limited to the maximum monthly amount in your Retiree Account. If claims are mistakenly paid or there was an overpayment due to misrepresentation, you will be responsible for reimbursing the HRA Plan for such excess amount. To recover excess payments, the HRA Plan may offset from future claims submitted and determined to be eligible for reimbursement. The overpayment may be recovered from the Retiree or the Retiree's Eligible Dependent. The right to offset does not limit this HRA Plan's right to recover overpayments in any other manner.

### *2. Who is an Eligible Dependent under the Plan?*

Eligible Dependents are individuals who fall into one of the categories set forth below. Additionally, an individual is not, and will cease to be, an Eligible Dependent once they become eligible for Medicare or once they lose coverage under the HRA Plan because the Retiree becomes entitled to Medicare. (However, see Article VI, COBRA Continuation Coverage, regarding an Eligible Dependent's ability to continue HRA Plan coverage upon the Retiree becoming entitled to Medicare.)

The categories are the following:

The person to whom you are legally married (spouse).

Your registered domestic partner in accordance with applicable state law.

Your (or your spouse's or your state registered domestic partner's) child who is under age 26 and who meets any of the following criteria:

- Your (or your spouse's or your state registered domestic partner's) natural child, stepchild, adopted child or child legally placed with you (or your spouse or your state registered domestic partner) for adoption;

- A child for whom you (or your spouse or your state registered domestic partner) have court-appointed legal guardianship; or

- A child for whom you (or your spouse or your state registered domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your (or your spouse's or your state registered domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if you complete and submit the Trust's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or your Effective Date and either:

- He or she is an enrolled child immediately before his or her 26th birthday; or

- His or her 26th birthday preceded your Effective Date and he or she has been continuously covered as your dependent on group coverage since that birthday.

All Eligible Dependents must be dependents under applicable law. The Retiree may enroll a new spouse within 60 days of marriage and/or enroll a new dependent child within 60 days of birth or adoption.

### *3. How Do I File a Claim for Benefits?*

You must deliver a completed claim form to the Trust Administrative Agent. The address is:

CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION
533 South Fremont Avenue, 6th floor Eligibility Dept.
Los Angeles, CA 90071-1706

The IRS requires substantiation of expenditures submitted for reimbursement. This requires a completed claim form.

The claim form includes information such as:

- The name of the Retiree;
- The name of the person on whose behalf health insurance premiums have been incurred;
- Proof of the health insurance premiums (such as receipt showing payment of the health insurance premium);
- The amount of the requested reimbursement;
- Other information regarding the claim may be requested by the Claims Administrator.

You must attach satisfactory documentation of the amount of the expense and the date(s) the health insurance premiums were incurred (a canceled check is not sufficient). You must also certify that each expense is eligible for reimbursement under this Plan, that it has not been previously reimbursed under this Plan or another health plan, and that it is not reimbursable from any other source. After your claim is reviewed, processed, and approved, you will receive a benefit amount up to the amount of your Account Balance. Claims with missing or illegible information will be denied, pending re-submission of complete and/or legible information.

### *4. How Often Are Claims for Reimbursement Paid?*

Benefits are paid every month up to the amount of the Account Balance. *Please note Account Balances do not roll over from month-to-month or year-to-year.* Unused HRA Account Balances will be forfeited back to the Trust at the end of the 60-day claims filing deadline.

### *5. When is a health insurance premium "Incurred"?*

For reimbursement of premiums, health insurance premiums (insurance premium) are incurred on the date paid; provided that during a participant's initial month of eligibility, premium payments incurred in the previous month shall be eligible for reimbursement. For example, if a participant is first eligible in June 2024, premium payment made in May 2024 will be eligible for reimbursement in June 2024 and then June 2024 premium payment will be eligible for reimbursement in July 2024, etc.

### *6. How Long Do I Have to Submit a Claim for Reimbursement?*

You have 60 days after the health insurance premiums were incurred to submit a correct and complete claim form to the Claims Administrator. Claims received will be reimbursed based on the Account Balance at the time the claim is submitted, not the Account Balance on the date the claim was incurred. Accordingly, it is important to submit claims as timely as possible each month. Reimbursements will be made via check and payable to the Retiree unless an Eligible Dependent continues to be enrolled under COBRA.

### *7. How Do I Enroll or Opt-Out of the HRA?*

Non-Medicare eligible retirees who meet the eligibility requirements of the HRA Plan on May 31, 2024 are automatically enrolled in this HRA Plan. They may still be required to provide sufficient documentation to show their dependents are eligible. Those who are automatically enrolled will still have to comply with the HRA Plan's reimbursement rules.

If you are a new Retiree on or after June 1, 2024, and you meet the eligibility requirements of this HRA Plan, you may enroll in this HRA Plan within 90 days of your retirement effective date. For new Retirees after June 1, 2024, if you fail to enroll within 90 days of your retirement effective date, you will not be eligible to enroll in the HRA Plan. The 90 day period does not extend the 60 day period for submitting claims for reimbursement.

Instructions on how to submit a claim will be mailed to auto-enrolled and new Retirees when they become eligible for the HRA benefit.

You or your Eligible Dependents may elect to opt out of the HRA Plan at any time by notifying the Trust Administrative Agent of your intention to opt out. If you opt out, any Account Balance remaining in your Retiree Account will be forfeited to the Trust. Also, if your Retiree Account has been unused for a 12-month period, you will automatically be disenrolled from the HRA Plan.

### **8. *What Happens to My Account if I Become Eligible for Medicare?***

The HRA Plan only provides benefits to Retirees and their Eligible Dependents who are ineligible for Medicare. If a Retiree or his or her Eligible Dependent is eligible to receive Medicare benefits or enrolls in Medicare, that individual will no longer be eligible to participate in the HRA Plan and any amounts available for reimbursement with respect to that individual's coverage, held in the Retiree Account will be forfeited to the Trust.

### *9. What Happens if I Return to Work for a Trust Contributing Employer?*

If you return to work for a Trust contributing employer and qualify for health coverage under the Trust, regardless of whether contributions are made on your behalf, your Retiree Account will be forfeited to the Trust. You are required to notify the Trust if you return to work for a Trust contributing employer.

### *10. **A**re Death Benefits Provided under the HRA?*

If a Retiree dies, the Retiree's Eligible Dependent(s) (if any) may elect COBRA continuation coverage (see COBRA section). If the Retiree dies and there are no Eligible Dependents, any remaining Account Balance will be forfeited to the Trust.

### *11. Could My Retiree Account Balance Ever Be Forfeited?*

A Retiree's Account Balance is forfeited on the earlier of:

a. The date on which you elect to opt out of the HRA and forfeit your account balance; or

b. At the end of each 60-day claims filing deadline; or

c. The last day your Retiree Account has been unused for a 12-month period; or

d. The date on which the Retiree dies (subject to Eligible Dependents' right to elect COBRA); or

e. The date the Retiree becomes Medicare eligible; or

f. The date the HRA Plan funds become exhausted or December 31, 2030 (whichever is sooner); or

g. For Retirees who first became eligible after June 1, 2024, 36 months after becoming eligible.

### *12. What Happens to Forfeited Amounts?*

Amounts forfeited under circumstances outlined above are returned to the Trust and used to pay other benefits and administrative expenses. In no case may these forfeitures revert to the Employer. There is no cash payout of the HRA account, except through the normal claims reimbursement process.

## VI. COBRA CONTINUATION OF COVERAGE

To obtain COBRA continuation coverage, your enrolled Eligible Dependents (Enrolled Dependent) must have a qualifying event and make a timely election to continue coverage. These requirements are described more fully below. Enrolled Dependents who have the right to elect continuation coverage under COBRA are called "qualified beneficiaries." There are no COBRA continuation rights for Retirees.

**COBRA Qualifying Events.** Your Eligible Dependent may elect COBRA continuation coverage for a maximum of 36 months if their coverage would otherwise end due to one of the following:

- Death of the Retiree;
- The Retiree becomes entitled to Medicare;
- Divorce or legal separation from the Retiree; or
- An enrolled dependent ceasing to meet the Plan's definition of an Eligible Dependent.

**COBRA Notification Responsibilities.** For any qualifying event, the Retiree or the Retiree's Eligible Dependent must notify the Trust Administrative Agent:

- Within 60 days of a death, divorce, legal separation, or Eligible Dependent child losing dependent status prior to age 26; or
- Upon becoming covered under any other group health plan, including Medicare, after electing COBRA continuation coverage.

**Election of COBRA Coverage.** Upon receiving notification that a qualifying event occurred, the Trust will notify the Retiree's Eligible Dependent of the right to elect continuation coverage. The Eligible Dependent must then select continuation coverage by the later of 60 days after the coverage ends or 60 days after receiving notification of the continuation rights from the Trust.

Failure to elect continuation coverage within this 60-day period will result in the loss of the right to elect COBRA continuation coverage.

**Types of COBRA Coverage Available.** If your Eligible Dependents choose continuation coverage, your Eligible Dependents are entitled to the same HRA Plan benefits you had in the month immediately before they lost coverage.

**Continuous COBRA Coverage Required.** Your Eligible Dependents' coverage under COBRA must be continuous from the date Trust coverage would have ended.

**End of HRA Benefits Under COBRA**

Continuation coverage will end on the earliest of the following dates:

- 36 months from the date continuation began for individuals whose coverage ended because of the death of the Retiree, divorce or legal separation from the Retiree, the dependent ceasing to meet the definition of an Eligible Dependent, or the Retiree's entitlement to Medicare; or
- The date the individual becomes covered under any other group health plan; or
- The date the individual becomes entitled to Medicare; or
- 36 months after the Retiree first became eligible to participate in the HRA Plan, if the Retiree first became eligible after June 1, 2024; or
- The date this HRA Plan ends.

Example: If the Eligible Dependent first becomes eligible for coverage under the HRA Plan on September 1, 2024, and subsequently becomes entitled to Medicare on September 1, 2025, continuation coverage under the HRA Plan will continue for the Eligible Dependent until August 31, 2027, or until the date that the dependent is no longer eligible to continue coverage under COBRA (due to Medicare entitlement or coverage under another group health plan) or the HRA Plan terminates, if sooner.

## VII. CLAIMS AND APPEAL PROCEDURES

A Retiree or Eligible Dependent may submit a claim for reimbursement of health insurance premium(s) to the Trust Administrative Agent as described in this booklet. For purposes of this section, the Retiree or Eligible Dependent is referred to as "the Claimant."

The Trust Administrative Agent shall notify the Claimant of the Plan's benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. In the event the Trust Administrative Agent determines that a request for benefits requires additional information, the Trust Administrative Agent shall provide the Claimant with written notice of its need for additional information within fifteen (15) days from the date the Claimant's request for Plan benefits was received. If prior to the expiration of the initial fifteen (15) day period special circumstances require an additional extension of time, the Trust Administrative Agent shall provide the Claimant with written notice of the extension, the special circumstances which require such extension and the date by which the Trust Administrative Agent expects to render its decision. The Claimant has twenty-eight (28) days from the date of the notice to perfect a claim for reimbursement. In no event shall the Trust Administrative Agent exceed a period of sixty (60) days total to review and respond to a claim, in the event of an extension.

If the Claimant's request for benefits is denied, in whole or in part, by the Trust Administrative Agent, the Trust Administrative Agent shall notify the Claimant of such denial and shall include in such notice, set forth in a manner calculated to be understood by the Claimant, the following:

- The specific reason or reasons for the denial; and

- Specific reference to pertinent provisions of this HRA Plan or applicable rule on which the denial is based; and

- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and

- A description of the Plan's review procedures and the time limits applicable to such procedures, including information regarding how to initiate an appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request.

Claimants shall have a period of 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination in writing in accordance with instructions provided by the Trust Administrative Agent.

Review of an adverse benefit determination on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Claimants shall be provided with the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits and, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. A document, record, or other information is relevant to a claim for benefits if it—

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

- Demonstrates compliance with the required administrative processes and safeguards in making the benefit determination; or

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

A review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate appeal fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual, and who is a named fiduciary of the Plan.

An appeal will be presented to the Trust’s Board of Trustees or appeals committee of the Board of Trustees at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed until the second quarterly meeting following receipt of the appeal.

The Board of Trustees will decide the appeal based upon the written record. In all cases, a copy of the

administrative file will be mailed to the Claimant. The Board of Trustees will provide the Claimant written notification of its decision within five business days of the appeal hearing. Where appropriate, the Board of Trustees may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing.

The decision will set out the specific reasons for an adverse decision, reference the Plan procedure involved, inform the Claimant that all information relevant to the claim is available upon request and free of charge, notify the Claimant of his or her rights under section 502(a) of ERISA, identify any internal rule or guideline relied on (or reference that it is available free of charge), and if a denial is based on a medical judgment, an explanation of the medical judgment applying it to the Claimant's case or a statement that such information is available.

If a decision cannot be reached at the initial meeting at which an appeal is heard, the Board of Trustees may defer a decision on an appeal until the next quarterly scheduled meeting, provided that written notice is provided to the Claimant.

If the Claimant remains dissatisfied after the issuance of the Board of Trustees decision on appeal, the Claimant may bring a civil action under ERISA § 502(a). Any litigation action in connection with the HRA Plan and SPD may only be brought in Federal District Court in Los Angeles County, California. Any civil action must be brought no later than 180 days after the date of issuance of the Board of Trustees' decision on an appeal. The question on review will be whether, in the particular instance, the Board of Trustees:

- Were in error upon an issue of law;
- Acted arbitrarily or capriciously in the exercise of their discretion; or
- Whether their findings of fact were supported by substantial evidence.

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim to the Board of Trustees, or
- The Board of Trustees has issued a decision on appeal; or
- You have exhausted the Plan's appeals processes for every issue you deem relevant.

The Summary Plan Description section of this booklet provides additional information on action you can take if you feel your right to a benefit has been improperly denied.

## VIII. HOW BENEFITS ARE TAXED

The Internal Revenue Code provides that Employer Contributions and any earnings used to pay for Benefits will not be subject to federal or state income taxes or to Social Security taxes. Benefit payments will not be reduced by income tax or social security withholding unless otherwise required under applicable state or federal law.

## IX. GENERAL ADMINISTRATIVE INFORMATION

**NAME OF PLAN:** HEALTH REIMBURSEMENT ARRANGEMENT PLAN FOR NON-MEDICARE ELIGIBLE ALASKA RETIREES

**NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR:** BOARD OF TRUSTEES OF SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST

**EMPLOYER IDENTIFICATION NUMBER (EIN):** 95-6042873

**PLAN NUMBER:** 501

**TYPE OF PLAN**

This Plan is a welfare benefit plan which provides health reimbursement account benefits to retirees. This Plan is a retiree only plan.

**TYPE OF ADMINISTRATION**

The Plan benefits are administered under a contract with the Trust Administrative Agent:

CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION
533 South Fremont Avenue, 6th floor Eligibility Dept.
Los Angeles, CA 90071-1706
Telephone: (213) 386-8590 or (800) 293-1370

**NAMES, TITLES AND ADDRESSES OF BOARD OF TRUSTEES:** (LISTED ON NEXT PAGE)

**AGENT FOR SERVICE OF LEGAL PROCESS / TRUST ADMINISTRATIVE AGENT**

SHANLEY APC
533 South Fremont Avenue, 9th floor; Los Angeles, CA 90071-1706
Telephone: (213) 488-4100.

Legal process may also be served on the Plan Administrator or the Trustees.

**PLAN CONTRIBUTIONS AND FUNDING**

The Plan is funded by contributions from a Trust. The amount of total future contributions, if any, is determined from time to time by the Board of Trustees. No employee contributions are permitted to the HRA Plan.

**ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS**

Previously made employer contributions are held in the Trust, which pays for benefits.

**PLAN YEAR**

January 1 to December 31.

**ELIGIBILITY, TERMINATION OF ELIGIBILITY, AND BENEFITS:**

Benefits, eligibility, and termination of eligibility requirements are as described in this summary plan description. If at any time you are unable to locate your summary plan description, an additional copy may be obtained from the Trust Administrative Agent.

## PLAN AMENDMENT AND TERMINATION PROVISIONS

The Board of Trustees has the absolute discretion to amend or terminate the HRA Plan or Trust at any time or replace the HRA Plan with a new HRA Plan. If the HRA Plan or Trust is terminated, participants and beneficiaries will not have any further rights, other than the payment of benefits for Eligible Health Expenses incurred and submitted for reimbursement before the HRA Plan or Trust was terminated. The amount and form of any final benefit will depend on any contract provisions affecting the HRA Plan.

## PLAN INTERPRETATION

The Board of Trustees has the responsibility and authority to construe, interpret and apply all of the terms of the HRA Plan and to make factual determinations. In exercising such responsibility and authority, the Board of Trustees may rely on available expertise and resources from the Trust Administrative Agent and other service providers to the Plan. The Board of Trustees will make every effort to exercise its authority in a fair and consistent manner.

## INFORMATION TO BE FURNISHED

You are required to sign documents and to provide the Board of Trustees and the Trust Administrative Agent with information and evidence as may reasonably be requested from time to time for the purpose of administration of the Plan. You are also required to timely inform the Trust Administrative Agent, in writing, if you have a new address or there are changed circumstances affecting eligibility, such as a divorce or marriage.

## QMCSO PROCEDURES

A participant may obtain, without charge, a copy of the procedures governing the Plan's Qualified Medical Child Support Order ("QMCSO") determinations from the Trust Administrative Agent.

## STATEMENT OF ERISA RIGHTS

As a participant under the Trust, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

### 1. Receive Information About Your Plan and Benefits

Examine, without charge, at the Trust Administrative Agent's office and at other specified locations, all documents governing the HRA Plan, including 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 Administrative Agent, copies of documents governing the operation of the HRA Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Trust Administrative Agent may make a reasonable charge for the copies.

Receive a summary of any applicable annual financial report. The Trust Administrative Agent is required by law to furnish each participant with a copy of this summary annual report.

### 2. Continued Group Health Plan Coverage

Continued health care coverage may be available for your Eligible Dependents if there is a loss of coverage under the HRA Plan as a result of a qualifying event under COBRA. Review this summary plan description and the documents governing the HRA Plan for a description of the rules governing your COBRA continuation coverage rights.

### 3. Prudent Actions by Plan Fiduciaries

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

### 4. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust Administrative Agent 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 Administrative Agent. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the 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 federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you 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.

### 5. Assistance with Your Questions

If you have any questions about this HRA Plan, you should contact Carpenters Southwest Administrative Corporation (CSAC); the Trust Administrative Agent. 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 NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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