HRA Plan

for

Non-Medicare Eligible Northwest Retirees

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

January 1, 2025
(To Sunset December 31, 2030)

INTRODUCTION

To Eligible Retirees and Eligible Dependents:

This Booklet and Summary Plan Description (SPD) summarizes the Health Reimbursement Arrangement Plan for Non-Medicare Eligible Northwest Retirees (HRA Plan) provided to non-Medicare eligible retirees and non-Medicare eligible dependents who were formerly enrolled in the Northwest Carpenters Health and Security Plan as of December 2024. This HRA Plan is administered by the Southwest Carpenters Health and Welfare Trust (Trust) as of January 1, 2025.

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. The benefits provided under the HRA Plan and Trust are not guaranteed and no individual has an accrued or vested right to the 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 and HRA Plan's benefits and conditions for eligibility, and, as with all benefits, the Board of Trustees reserves the right to terminate, suspend, discontinue or amend the HRA Plan provisions at any time and for any reason.

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

To the extent the SPD is inconsistent with any applicable laws or regulations, the HRA Plan will be administered consistent with such 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 Northwest Retirees (HRA Plan) in a manner that you can easily understand. If you have any questions after reading this document, please contact the Trust Administrative Agent, Carpenters Southwest Administrative Corporation, at (800) 293-1370 or (213) 386-8590.

I. THE PURPOSE OF THE PLAN

The HRA Plan is available to Eligible Retirees and their Eligible Dependents who satisfy the eligibility requirements set forth below, enroll in the HRA Plan (as described, below), and otherwise comply with this HRA Plan document. Eligible Retirees may use the amounts allocated to their Retiree HRA Accounts to reimburse the cost of individual health insurance premiums.

II. DEFINITIONS

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

1. Account Balance means the monthly amount available for reimbursement from the Retiree HRA Account to those Eligible Retirees who satisfy the eligibility requirements set forth herein, enroll in the HRA Plan, and have not opted out.

2. Benefit means any amount paid to an Eligible Retiree as reimbursement for Eligible Medical Expenses.

3. Enrollment Date means the first day of the month in which an Eligible Retiree incurs an Eligible Medical Expense for which the Retiree is eligible and receives reimbursement under the HRA Plan via submitted claim.

4. Eligible Retiree – means the individual meets the Eligibility Criteria as defined in Section III.

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

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

7. HRA Plan Coverage means any month in which an Eligible Retiree and their Eligible Dependents (if any) are enrolled in the HRA Plan and eligible to receive reimbursement. Eligible Retirees may first enroll in HRA Plan Coverage for themselves and their Eligible Dependents, at any time after first becoming eligible to participate, by submitting an initial claim for reimbursement to the Trust Administrative Agent. An Eligible Retiree or Eligible Dependent may opt out of HRA Plan Coverage after their initial enrollment, by submitting a completed HRA Plan Opt-Out Form to the Trust Administrative Agent, and may re-enroll by submitting another claim for reimbursement, in no event will an Eligible Retiree's or Eligible Dependent's eligibility for reimbursement under the HRA Plan extend beyond 36 months from the Eligible Retiree's Effective Date. (Refer to Section III Eligibility & Participation for further details on Opting out of coverage).

8. Eligible Retiree HRA Account refers to the bookkeeping or notional account maintained by the Trust Administrative Agent in the name of an Eligible 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 Eligible Retirees and their Eligible Dependents, as those terms are defined herein.

III. ELIGIBILITY AND PARTICIPATION

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

1. Are not receiving and are not eligible to receive Medicare benefits; and

2. Have worked at least 7,500 hours for which employer contributions were received by the Northwest Carpenters Health and Security Plan (Northwest Plan) and/or the Oregon-Washington Carpenters-Employers Health and Welfare Plan during the 120 months immediately prior to the Retiree's retirement effective date (for this purpose, hours for which employer contributions are made on or after January 1, 2025, to the Southwest Carpenters Health and Welfare Plan, on behalf of a former participant in the Northwest Plan, shall be counted towards the 7,500 hours requirement); and

3. Are retired and receiving a monthly benefit or have received a lump sum benefit from the Northwest Carpenters Retirement Plan, the Washington, Idaho, Montana, Carpenters-Employers Retirement Plan, the Cement Masons and Plasterers Retirement Plan, or the Southwest Carpenters Pension Plan (inclusive of any predecessor or successor plans).

HRA Plan Coverage for you and your Eligible Dependents will commence on the first day of the month in which you incur an Eligible Medical Expense for which you complete and file an HRA Plan claim for premium reimbursement with the Trust Administrative Agent. If you wish to opt out of HRA Plan Coverage after first enrolling, you must complete an HRA Plan Opt-Out Form and return it to the Trust Administrative Agent's office. The change will be effective the first of the month following the month in which the Trust Administrative Agent receives your completed HRA Plan Opt-Out Form. If you fail to submit a claim for reimbursement from the HRA Plan for three consecutive months, you will be treated as though you opted out of HRA Plan Coverage for those three months and for each month in which you fail to submit a claim for reimbursement thereafter. If you wish to re-enroll in HRA Plan Coverage after having opted out of HRA Plan Coverage, you must re-enroll by submitting a claim for reimbursement with the Trust Administrative Office and producing evidence of continuation of coverage during the months in which you opted out. If 36 months has not yet passed since you originally enrolled in HRA Plan Coverage, and you are otherwise still eligible, the change will be effective the first of the month in which the claim for reimbursement and evidence of continuation of coverage is received.

Please note that, although Eligible Retirees and Eligible Dependents wishing to opt out of HRA Plan Coverage may do so by not submitting a claim for reimbursement for three consecutive one-month periods, individuals wishing to disenroll are encouraged to submit a completed HRA Plan Opt-Out form to the Trust Administrative Agent. Failure to do so could jeopardize your ability to claim a premium tax credit on the exchange for any month in which you failed to disenroll.

IV. HRA BENEFITS

The Trust has established this HRA Plan to reimburse non-Medicare eligible Retirees for monthly premium expenses incurred by them and their Eligible Dependents, to obtain individual health insurance coverage provided on a state exchange. The HRA Plan is funded with contributions made as of January 1, 2025 and held by the Trust. No new contributions will be allocated to the HRA Plan on or after January 1, 2025. For each enrolled non-Medicare eligible Retiree, each month the Trust shall make available to each Retiree Account an amount determined by the Trust. The Board of Trustees shall determine the monthly amount to be made available for reimbursement. Should the Board of Trustees adjust the monthly amount that will be made available to you for reimbursement, such adjustment will not go into effect until after you have been provided adequate notice.

As of January 1, 2025, the monthly amount that will be made available to eligible Retirees and each of their Eligible Dependents enrolled in the HRA Plan is $500 per eligible individual for a period not to exceed 36 months commencing from the date the eligible Retiree initially enrolled.

Any unused Account Balance in the individual's Retiree HRA Account ***will not*** roll over from month-to-month or year-to-year. Amounts credited to a Retiree HRA Account in a calendar month, during a period of HRA Plan Coverage, may only be used to reimburse for premium expenses paid by the eligible Retiree or the Retiree's Eligible Dependents for individual marketplace coverage in the month in which the Retiree HRA Account was credited. Claims must be submitted for reimbursement within 90 days following the month of coverage, after which time, any unused Account Balance will be forfeited back to the Trust.

If you stop participating in the HRA Plan either because you lose eligibility or opt-out of HRA Plan Coverage and do not re-enroll, any amount remaining in your Retiree Account will be forfeited back to the Trust. In no event will your monthly reimbursements exceed the notional monthly amount made available through your notional Retiree HRA Account by the Trust.

Your access to the HRA Plan will terminate when you become Medicare eligible, stop participating in the HRA Plan for any reason, or 36 months after you initially enrolled. (Also see Section VI, COBRA Continuation of Coverage, regarding the end of coverage for the Enrolled Dependent.)

V. BENEFIT REIMBURSEMENT RULES

1. What Expenses Can Be Reimbursed under the Plan?

The HRA Plan will only reimburse health insurance premiums for a period of coverage commencing on or after the first date the Trust credits your Retiree Account with a contribution. All claims must be submitted for reimbursement within 90 days from the first day of the coverage month for which the Eligible Premium Expense was incurred. During an eligible Retiree's and Eligible Dependent's initial month of eligibility, premiums paid by the Retiree or his or her Eligible Dependent in the prior month for a period of coverage commencing after the Retiree and his or her Eligible Dependent first become eligible for HRA Plan Coverage, are eligible for reimbursement. For example, if an eligible Retiree is first eligible in January 2025, a premium paid in December 2024 for January 2025 coverage will be eligible for reimbursement in January 2025 and the January 2025 premium payment for February 2025 coverage will be eligible for reimbursement in February 2025, etc.

Eligible Medical Expenses are limited to health insurance premiums paid by the eligible Retiree or the eligible Retiree's Eligible Dependent for the purchase of individual or family coverage on a state exchange, 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 (e.g., a health flexible spending account (FSA), health savings account (HSA), or another health reimbursement arrangement (HRA)) or insurance policy covering you or an Eligible Dependent (including, but not limited to, Social Security, Medicare, Medicaid), or if you or your Eligible Dependent 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 Plan. Benefits will always be limited to the maximum monthly amount available for reimbursement. 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 eligible Retiree or the eligible 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?

An Eligible Dependent is an individual who is not yet eligible for Medicare and who falls into one or more of the following categories:

i. The person to whom you are legally married (spouse) so long as your spouse submits evidence of continuity of health coverage that is the same or comparable to your health coverage (e.g., your spouse cannot be covered under a higher deductible health plan) to the Trust Administrative Agent.

ii. Your registered domestic partner in accordance with applicable state law so long as your registered domestic partner submits proof of continuity of health coverage that is the same or comparable to your health coverage (e.g., your registered domestic partner cannot be covered under a higher deductible health plan) to the Trust Administrative Agent.

iii. 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 for adoption with you, your spouse, or your state registered domestic partner;

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

iv. A child for whom you, your spouse, or your state registered domestic partner are required to provide coverage by a legal qualified medical child support order (QMCSO). Your, 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 a 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 enrolled in the HRA Plan, as your Eligible Dependent, 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 in the Northwest Carpenters Health and Security Plan or the Southwest Carpenters Health and Welfare Plan since that birthday.

All Eligible Dependents must be dependents under applicable law. If you are already enrolled in the HRA, you may enroll a new spouse within 60 days of marriage and/or enroll a new dependent child within 60 days of birth, adoption, or placement for adoption.

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 eligible 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 eligible Retiree becoming entitled to Medicare.)

3. How Do I File a Claim for Benefits?

You must deliver a completed claim form to the Trust Administrative Agent. Claims should be mailed to:

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 eligible 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 and month of coverage that was purchased);
- 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, the date(s) the health insurance premiums were incurred (a canceled check is not sufficient), and the coverage month(s). 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 not to exceed 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?

Reimbursements are processed monthly. Benefits are paid for each month in which you or your dependent are enrolled in the HRA Plan and for which a complete claim is submitted, up to the amount of the Account Balance allocated for each coverage month or the amount of the claim—whichever is lower. ***Please note unclaimed Account Balances do not roll over from month-to-month or year-to-year nor to a dependent's account.*** You must submit a claim for reimbursement within 90 days from the first day of the coverage month for which your health insurance premium was paid. If you do not use all the amounts allocated to your Retiree HRA Account during a month of HRA Plan Coverage, your unused Account Balance will be forfeited back to the Trust at the end of the 90-day claims filing deadline.

5. When is a health insurance premium "incurred"?

An Eligible Medical Expense is "incurred" when the medical care is provided not when you or your Eligible Dependent is billed, charged, or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g., pre-payment to a carrier for premiums) will not be reimbursed until the month in which the coverage is provided. For example, if a participant is first eligible in January 2025, a premium paid in December of 2024 for January 2025 coverage will be eligible for reimbursement in January 2025 and then the January 2025 premium payment for February 2025 coverage will be eligible for reimbursement in February 2025, etc.

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

You have 90 days from the first of the coverage month in which your health insurance premium was incurred to submit a correct and complete claim form to the Trust Administrative Agent. For example, if premiums are paid for the coverage month of February, the claim must be submitted within 90 days from February 1st. Claims received will be reimbursed based on the Account Balance in your Retiree HRA Account at the time the health insurance premium was incurred, not the Account Balance in your Retiree HRA Account allocated for the period(s) of coverage purchased. Accordingly, it is important to submit claims as timely as possible each month and in no event later than 90 days from the first day of the month for which coverage

was purchased. Reimbursements will be made via check (or direct deposit, if this option becomes available and the eligible Retiree provides accurate banking information) and payable to the eligible Retiree unless the claim for reimbursement is for an Eligible Dependent who continues to be enrolled under COBRA, in which case the reimbursement will be made to the Eligible Dependent who provides a valid address.

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

Non-Medicare eligible retirees who satisfy the eligibility requirements of the HRA Plan on December 31, 2024 are considered eligible and may enroll in HRA Plan coverage by submitting a claim for premium reimbursement; however, they may still be required to provide sufficient documentation to verify the eligibility of any of their enrolled dependents. Individuals will be deemed to have enrolled and are effective in HRA Plan Coverage the first of the coverage month for which a claim has been timely submitted for premium reimbursement.

Once an eligible Retiree is deemed enrolled under the HRA, he/she may opt-out of HRA Plan Coverage to take a federal subsidy or premium tax credit on a state exchange or enroll in other group health plan coverage, by completing an HRA Plan Opt-Out Form, available at the Trust Administrative Agent's office. The election will be effective the first of the month following the month in which the Trust Administrative Agent receives the completed HRA Plan Opt-Out Form. An eligible Retiree will also be deemed as having Opted Out if they cease to submit a claim for 3 consecutive coverage months. (Refer to Section III for additional eligibility rules).

A dependent's eligibility for HRA Plan Coverage is tied to the eligibility of the eligible Retiree, therefore, any dependents of an eligible Retiree waiving HRA Plan Coverage, who might otherwise be eligible for HRA Plan Coverage, are ineligible for any period during which the eligible Retiree opts-out of HRA Plan Coverage or is deemed to have Opted Out as a result of not submitting a claim for 3 consecutive coverage months.

If 36 months from the date of the eligible Retiree's initial enrollment date has not yet expired, an eligible Retiree who has opted out of HRA Plan Coverage may reenroll by submitting evidence of continuity of health coverage and a completed HRA Plan reimbursement form with the Trust Administrative Agent.

Although your legally married spouse or registered domestic partner may also elect to take a federal subsidy or premium tax credit on the exchange in lieu of receiving coverage under this HRA Plan, in order to constitute your Eligible Dependent and be eligible for coverage under the HRA Plan, your spouse or registered domestic partner must submit evidence of continuity of health coverage that is the same, or comparable to yours (e.g., your spouse cannot be covered under a higher deductible health plan) to the Trust Administrative Agent.

Instructions on how to submit a claim will be mailed to eligible Retirees when they become eligible for HRA Plan Coverage.

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

The HRA Plan only provides benefits to eligible Retirees and their Eligible Dependents who are ineligible for Medicare. If an eligible 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 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 for the month(s) you were covered for health coverage by the Trust. A return to work means you are no longer

"retired" within the meaning of Section III. You are required to notify the Trust if you return to work for a Trust contributing employer.

10. Are Death Benefits Provided under the HRA?

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

11. Could My Amounts Available for Reimbursement Ever Be Forfeited?

An eligible Retiree's amount available for reimbursement is forfeited on the earlier of:

a. The first of the month following the date on which the eligible Retiree submits a completed HRA Plan Opt-Out Form to the Trust Administrative Agent; or

b. The first of the month following 3 consecutive months in which no claim has been received by the Trust Administrative Agent; or

c At the end of each 90-day claims filing deadline; or

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

e. The date the eligible Retiree becomes Medicare eligible; or

f. On December 31, 2030, assuming there are sufficient funds up to that date; or

g. 36 months from the date the eligible Retiree first enrolled in HRA Plan Coverage.

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 Dependent (Enrolled Dependent) must experience a qualifying event that would otherwise result in your Enrolled Dependent losing coverage under this HRA Plan and make a timely election to continue coverage under COBRA. 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 eligible Retirees under the HRA Plan.

COBRA Qualifying Events. Your Enrolled Dependent may elect COBRA continuation coverage for a maximum of 36 months from the date the eligible Retiree initially enrolled in HRA Plan Coverage if their coverage under this HRA Plan would otherwise end due to one of the following Qualifying Events:

- Death of the eligible Retiree;
- The eligible Retiree becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Divorce or legal separation from the eligible Retiree; or

- An Enrolled Dependent child ceasing to meet the HRA Plan's definition of an Eligible Dependent.

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

- Within 60 days of a death, divorce, legal separation, or an Enrolled 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 notice of a qualifying event, the Trust Administrative Agent will notify the eligible Retiree's Enrolled Dependent of the right to elect continuation coverage. The Enrolled Dependent must then select continuation coverage by the later of 60 days after the date HRA Plan Coverage ends or 60 days after receiving notification of the continuation rights from the Trust Administrative Agent.

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

After electing COBRA continuation coverage, the eligible Retiree or the eligible Retiree's spouse or dependent must notify the Trust Administrative Agent upon becoming covered under any other group health plan or Medicare.

Types of COBRA Coverage Available. If an Enrolled Dependent elects continuation coverage, the Enrolled Dependent is entitled to the same HRA Plan benefits they had in the month immediately before losing coverage.

Continuous COBRA Coverage Required. Your Enrolled Dependent's coverage under COBRA must be continuous from the date HRA Plan Coverage would have otherwise ended.

End of HRA Benefits Under COBRA. Continuation coverage will end on the **earliest** of the following dates:

- The date the Enrolled Dependent becomes covered under any other group health plan; or

- The date the Enrolled Dependent becomes entitled to Medicare; or

- The date the Enrolled Dependent waives HRA Plan Coverage; or

- 36 months from the first of the month in which the eligible Retiree initially elected HRA Plan Coverage; or

- The date this HRA Plan ends.

Example: Eligible Retiree first enrolls himself and his Eligible Dependent, who is his spouse, for HRA Plan Coverage on September 1, 2025. The eligible Retiree subsequently becomes entitled to Medicare on September 1, 2026, and the eligible Retiree's spouse, who is still an Enrolled Dependent in the HRA Plan as of that date, timely notifies the Trust Administrative Agent and makes a COBRA election to continue coverage under the HRA Plan. Assuming the spouse does not lose eligibility to continue coverage under COBRA due to Medicare entitlement or becoming covered under another group health plan, and assuming that the HRA Plan is not terminated sooner, the spouse's coverage under the HRA Plan will continue until August 31, 2028 (i.e., upon

the expiration of 36 months from the date that the eligible Retiree first elected HRA Plan Coverage for himself). If instead, in this example, the spouse becomes covered under any other group health plan or entitled to Medicare on December 1, 2026, HRA Plan Coverage for the spouse will end on December 1, 2026.

VII. CLAIMS AND APPEAL PROCEDURES

An eligible 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 eligible 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, but not later than 30 days after receipt of the claim. In the event the Trust Administrative Agent determines that a claim for benefits requires additional information, the Trust Administrative Agent shall provide the Claimant with written notice of its need for additional information within 15 days from the date the Claimant's claim for Plan benefits was received. If prior to the expiration of the initial 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 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 60 days total to review and respond to a claim, in the event of an extension.

If the Claimant's claim 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 Statement of ERISA Rights 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 (HRA) PLAN FOR NON-MEDICARE ELIGIBLE NORTHWEST 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 eligible retirees and eligible dependents. This Plan is a retiree-only HRA 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

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.

HRA PLAN CONTRIBUTIONS AND FUNDING

The HRA Plan is funded by contributions from a Trust. 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.

HRA 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.

HRA PLAN AMENDMENT AND TERMINATION PROVISIONS

Although it is the intention of the Board of Trustees to maintain this HRA Plan through December 31, 2030, the Board of Trustees has the absolute discretion to amend or terminate the HRA Plan or to replace the HRA Plan with a new HRA Plan at any time. The HRA Plan will automatically terminate as of December 31, 2030, unless otherwise extended by the Board of Trustees in their absolute authority and discretion. 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 Medical 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.

HRA 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 HRA 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 HRA 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 HRA Plan's Qualified Medical Child Support Order (QMCSO) determinations from the Trust Administrative Agent.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your HRA 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 HRA 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.

Board of Trustees

Address correspondence to:

Carpenters Southwest Administrative Corporation
533 South Fremont Avenue, 7th Floor
Los Angeles, CA 90071

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