SUMMARY PLAN DESCRIPTION FOR

PRECISION MANUFACTURING BENEFITS TRUST WELFARE BENEFIT PLAN

January 1, 2018

INTRODUCTION

This document, along with the benefit information furnished by your insurance provider(s), is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). This summary highlights your rights and obligations under the PRECISION MANUFACTURING BENEFITS TRUST WELFARE BENEFIT PLAN ("Plan"). Benefits under the Plan are provided through several insurance and managed care providers, and are subject to the provisions of the Plan, the Trust Agreement, your employer's Adoption Agreement, and the determination of the PI or health insurance issuer.

Since this is only a summary, all of the details of the Plan are not covered, and you should contact the Plan Administrator or health insurance issuer if you still have questions about your coverage. The Board of Trustees reserve the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.

Noticia de Asistencia de Lenguaje Extranjero: Este folleto contiene un sumario en ingles de sus derechos del Plan y los beneficios bajo Precision Manufacturing Benefits Trust Welfare Benefit Plan. Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiquese con el Administrador del Plan a su oficina en 3444 Camino del Rio North, Suite 101, San Diego, California 92108. Horas de oficina son de 8:30 a.m. a 5:00 p.m. de Lunes a Viernes. Tambien se puede comunicar con el Administrador por telefono al (619) 280-2009 para asistencia.

SUMMARY PLAN DESCRIPTION

A. Basic Plan Information

1. Name of Plan.

PRECISION MANUFACTURING BENEFITS TRUST WELFARE BENEFIT PLAN ("Plan").

2. Name and Address of Plan Sponsor.

Women of Manufacturing & Empowering Network and California Nonprofit Mutual Benefit Corp. PO Box 4141 Covina, CA 91723

3. Participating Employer.

A Participating Employer is an employer who has executed an Adoption Agreement and has agreed to be bound by the provisions of the Trust Agreement for the Precision Manufacturing Benefits Trust. The Plan allows participation of more than one employer. You may receive upon written request of the Plan Administrator information as to whether a particular employer participates in the Plan.

4. Plan Sponsor's Employer Identification Number (EIN): 90-0611915.

5. Plan Number (PN): 501.

6. Type of Plan and Funding.

This is a welfare benefit Plan that provides insured group medical and supplemental benefits through a multiple employer trust fund. All benefits are fully insured. Contributions are paid by participating employers to the trust fund. The trust name is PRECISION MANUFACTURING BENEFITS TRUST.

7. Plan Administrator and Type of Administration.

The Plan is administered by a professional Plan Administrator. If you have questions about the Plan, please contact:

Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, CA 92018
(619) 280-2009
1-800-866-7559

8. Agent for Service of Legal Process.

The name and address of the Plan's agent for service of legal process are:

Melissa W. Cook
Melissa W. Cook & Associates
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

Service of legal process may also be made on the Plan Administrator identified in the preceding Section or on any Plan Trustee identified in the following section.

9. Plan Trustees.

The names and addresses of the Plan Trustees are:

Patricia A. Serio
3444 Camino del Rio North, Suite 101
San Diego, CA 92018

Suzette Peterson
3444 Camino del Rio North, Suite 101
San Diego, CA 92018

Anita Ron
3444 Camino del Rio North, Suite 101
San Diego, CA 92018

10. Source of Plan Contributions.

Contributions are made by Participating Employers for their employee Participants covered under the Plan. Contributions are set at amounts needed to pay premiums for coverage under the group policy and to pay for the Plan's administrative expenses.

11. Plan Year.

The Plan Year is January 1 through December 31.

12. Plan Benefits.

Details of the Plans selected above are provided by the individual insurance carriers and will either be provided along with this Summary Plan Description or with your enrollment application materials.

13. Role of Health Insurance Issuer.

The benefits provided under the United Healthcare Plans are insured and underwritten by United Healthcare, a UnitedHealth Group Company. Administrative services in connection with this health plan, including payment of claims, are performed by United Healthcare. Should you have any questions for the insurer, you may direct inquiries to:

HMO
United Healthcare
Attn: Claims Department
P.O. Box 30968
Salt Lake City, Utah 84130-0968

PPO
United Healthcare
Attn: Claims Department
PO Box 30555
Salt Lake City, UT 84130

The group dental insurance benefits provided under the United Healthcare Dental Plans are insured and underwritten by United Healthcare, a UnitedHealth Group Company. Administrative services in connection with this dental plan, including payment of claims, are performed by United Healthcare. Should you have any questions for the insurer, you may direct inquiries to:

HMO and PPO United Healthcare
PO Box 30567
Salt Lake City, UT 84130-0567

The group vision benefits provided under the Vision Plans are insured and underwritten by United Healthcare, a UnitedHealth Group Company. Administrative

services in connection with the vision plan, including the payment of claims, are performed by United Healthcare. Should you have any questions for the insurer, you may direct inquiries to:

United Healthcare Vision Claims Department
Out-of-Network Claims
PO Box 30978
Salt Lake City, UT 84130

The group term life insurance benefits provided under the Unimerica Plans are insured and underwritten by Unimerica, a UnitedHealth Group Company. Administrative services in connection with the group term life plan, including payment of claims, are performed by Unimerica. Should you have any questions for the insurer, you may direct inquiries to:

United Healthcare
PO Box 7149
Portland, ME 04112-7149

14. Filing a Claim.

Procedures for submitting claims and obtaining benefits are outlined in the insurance provider's benefits information materials. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

15. Appealing a Claim Denial.

Except for eligibility issues, the Trustees have delegated the review of denied benefit claims to the health benefits providers identified above. The health care providers' claims review and appeal procedures will constitute the sole and exclusive procedures under the Plan available to a participating employee or beneficiary who is dissatisfied with the disposition of a benefit claim, and will comply with the requirements of ERISA. A copy of such procedures is provided with this Summary Plan Description. No lawsuit may be brought with respect to Plan benefits until all such administrative procedures have been exhausted for every issue deemed relevant by the participating employee or beneficiary.

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 to the Board of Trustees. 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.

The following describes the process to appeal actions of the Administration Office with regard to the Trust's eligibility provisions, type or duration of benefits and any action of the Board of Trustees. <u>The Appeals Procedure does not apply to benefits obtained through HMOs, PPOs or any insured benefits</u>.

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 of Trustees 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 shall be resolved by the Board under and pursuant to the Plan, your employer's Adoption Agreement and the Trust Agreement.

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 of Trustees 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 of Trustees shall be notified of such decision in writing by the Board of Trustees and may petition the Board of Trustees 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 of Trustees and shall be filed with or received by the Administration Office within 60 days after the date shown on the notice to the petitioner of the decision of the Board of Trustees.

c. Upon good cause shown, the Board of Trustees may permit the petition to be amended or supplemented. The failure to file a petition for reconsideration within such 60-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 of Trustees.

d. Upon receipt of a petition for reconsideration, the Board of Trustees, 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 of Trustees shall be made no later than the date of the quarterly meeting of the Board that immediately follows the Administrative 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 Administrative 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 Administrative Office's receipt of the request for reconsideration and the Administrative 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 Administrative 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 of Trustees 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 or the Plan until after the claim therefore has been submitted and determined by the Board of Trustees and, thereafter, the only action that may be brought is one to enforce the decision of the Board of Trustees.

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 of Trustees 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 Trustees 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.

Special Provisions for Disability Claims and Appeals

Claims filed by a Participant to continue coverage under the Plan for a dependent child over age 26 due to physical or mental disability are subject to certain additional safeguards. These claims and appeals shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination. Benefit denial notices shall provide a complete discussion of the reasons that the disability claim was denied and the standards applied in reaching the decision. Claimants shall be provided with timely notice of their right to access their entire administrative claim file and other relevant documents and shall be guaranteed the right to present evidence and testimony in support of their claim during any appeal process. Claimants shall be given notice and a fair opportunity to respond in the event that the Board of Trustees utilizes new or additional evidence or rationales to support its position at the appeal stage. Any rescission of disability benefit coverage shall constitute an adverse benefit determination and is subject to the Fund's Claims and Appeals Procedures.

16. No Vested Benefits.

Benefits under this Plan are NOT vested. The Board of Trustees 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 of Trustees may require new or greater premiums, co-payments, or deductibles at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

17. Termination of the Plan.

The Board of Trustees do not promise the continuation of any benefits nor do they promise any benefit at or during retirement. The Plan may be terminated at any time by the Trustees. Benefits may be terminated also by the Participating Employer's failure to make contributions or by the termination or expiration of the Participating Employer's agreement adopting the Plan.

Upon termination of the Trust Fund, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Participants and their beneficiaries under the Plan.

18. Statement of ERISA Rights.

As a participant in the 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:

a. Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the 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.

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.

b. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

c. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people 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 you employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

d. Enforce Your Rights

If your claim for a 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 Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. 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 Plan fiduciaries misuse the Plan's money, of if you are discriminated against asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The Court will decide who should pay court costs and legal fees. If you 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.

e. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, 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 publication hotline of the Employee Benefits Security Administration.

19. Maternity Benefits.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain

authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

20. Qualified Medical Child Support Order.

A Qualified Medical Child Support Order ("QMCSO") issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan Participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan Participants and beneficiaries can obtain, without charge, a copy of these procedures from the Plan Administrator.

B. Eligibility Rules

The following information describes the conditions pertaining to your eligibility to receive benefits. A detailed summary of benefits is furnished by your insurance provider and certain limits on participation may be included in your employer's subscription agreement. Please contact the Plan Administrator if you have any questions regarding your coverage.

1. Coverage of Employees.

The Participating Employer has elected to offer coverage to its employees as set forth in its Adoption Agreement.

2. Eligibility of Employees.

a. Becoming Insured.

Reported Employees will become eligible for coverage on the first day of the month following the eligibility waiting period elected by their employer. Employees who are covered by a collective bargaining agreement are not eligible to participate.

b. Termination of Your Insurance.

Your insurance will end on the earliest date shown below:

(1) The last day of the calendar month in which you cease to qualify as an eligible employee. The Plan deems the employee-employer relationship to end on the date the employee stops full-time active work for a participating employer.

(2) The last day of the month in which your employer ceases to be a participating employer.

(3) The last day of the month in which your participating employer has paid premiums for your insurance.

(4) The date the group policy terminates.

c. Insuring Dependents.

Only a person who meets the definition of dependent may become insured for dependents' insurance under the group policy. To become insured, the person must:

(1) Qualify as a dependent;

(2) Be enrolled for the dependents' insurance through your participating employer;

(3) Reach an eligibility date.

Eligible Dependent - The term "dependent" means only your spouse or domestic partner and child of an age within the Age Limit for Dependent Children shown below. The definitions of "child" and "dependent" are outlined in the insurance providers' benefit information materials and includes any child covered pursuant to a QMCSO.

Age Limit for Dependent Children – Dependent health coverage is available to children until the child reaches the age of 26. Eligibility of the child does not depend upon marital status, student status, or tax dependency of the child.

Exception to Age Limit - If an unmarried dependent child, when he or she reaches the Age Limit for Dependent Children shown above, is insured under the group policy, chiefly depends on you for support and maintenance, and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to qualify as a dependent for coverage until the earlier of the following dates: (a) the date he or she recovers from the handicap; and (b) the date he or she no longer chiefly depends on you for support and maintenance.

Eligibility Date - A dependent's eligibility date is the later of: (a) your eligibility date; or (b) the date the person qualifies as your dependent.

d. Insuring Domestic Partners.

A domestic partner is eligible for dependent coverage. To be eligible, an employee requesting domestic partner coverage and the domestic partner must meet certain criteria. In addition, only a person who meets the definition of domestic partner may become insured for domestic partner coverage under the group policy. To become insured, the employee and the domestic partner, among other things, must:

(1) Have a common residence;

(2) Not be married to someone else or be a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;

(3) Be capable of consenting to the domestic partnership;

(4) Not be related by blood in a way that would prohibit marriage; and

(5) Both be at least the minimum age of consent in the state in which you reside.

e. Termination of a Dependent's Insurance.

A dependent's insurance will end on the earliest date shown below:

(1) The last day for which premiums are paid for your dependents insurance.

(2) The last day of the month in which the person no longer qualifies as a dependent.

(3) The date your employees' insurance ends.

3. Coverage of Former Medicaid or State Children's Health Insurance Program Participants.

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides new enrollment rights of eligible individuals. The Plan provides the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

(1) An employee or eligible dependent who is covered under Medicaid or the State Children's Health Insurance Program ("SCHIP") and loses coverage under Medicaid or SCHIP because the employee or dependent is no longer eligible for such coverage may request coverage under the Plan within sixty (60) days of the loss of Medicaid or SCHIP coverage. Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outside of the regular open enrollment period; and

(2) An employee or eligible dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60) days after such eligibility is determined. State-specific notices will be provided to employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

4. 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.

5. 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; or
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.

6. Continuing Coverage (COBRA).

IF YOUR COVERAGE ENDS BECAUSE OF:	*COVERAGE MAY CONTINUE FOR UP TO:*
Termination of employment (for any reason other than gross misconduct) or reduction in work hours	18 Calendar Months* (*29 Calendar Months (18 Calendar Months plus an additional 11 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 Member or his or her Dependent is totally disabled (as determined by Social Security). Under CAL-COBRA , members receive an additional 18 Calendar months of coverage.
Death of Member Member's entitlement to health care coverage under Medicare Legal separation, divorce, cessation of domestic partnership Dependent Child no longer qualifies for Dependent coverage under the Plan	36 Calendar Months for Dependent

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the Plan participants (covered employees and dependents except domestic partners) be allowed to continue their medical provided by the Plan at their own expense

following certain qualifying events, which request in a loss of coverage. The premium is 102% of the cost of coverage and administrative expenses.

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, you are eligible to receive an additional 18 months of coverage.

Disability-Extended Coverage

If you or an eligible dependent are 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.

Dependent 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 lose coverage due to your death, your 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 former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce, or legal separation your former spouse may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse'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.

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 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 and administrative expenses.

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, which 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; and

g) The expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.

If your coverage ends because of the 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 Trust Fund will then transmit a notice of COBRA continuation rights and an application related to the coverage.

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 coverage's elected.

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 enroll in an individual conversion health plan provided to the Plan by certain service providers (such as an HMO or insurance company). Information related to 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 Fund's HMO program and you are terminated from the program because you move out the HMO's service area before the applicable COBRA period expires and the 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 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.

5. Continuing Coverage (USERRA).

If you experience a leave of absence from your employment to perform service in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides you with rights to elect to continue your coverage under the

Plan that is separate from and in addition to COBRA continuation coverage rights. Uniformed Services means the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also includes full-time National Guard duty, the commissioned corps of the Public Health Service, and any other persons designated by the President in a time of war or national emergency. Service in the uniformed services means voluntary or involuntary duty, active duty, and inactive duty for training. It also includes periods away from work for an examination to determine fitness to perform duty.

If you are a Participating Employee, you have a right to elect continuation coverage under USERRA for yourself and your covered dependents if you would otherwise lose

coverage under the Plan because of service in the uniformed services. Unlike under COBRA, your dependents do not have an independent right to elect USERRA continuation coverage.

Under USERRA, you may elect to continue coverage under the Plan up to the lesser of (a) 24 months or (b) the date you return or should have returned to active employment, or, if applicable, applied for reemployment. Unlike COBRA, there are no additional qualifying events that would entitle you to extend the period of continuation coverage beyond the 24-month period. In addition, there is no entitlement under USERRA for any extension based on your disability or the disability of a qualified beneficiary. USERRA continuation coverage is identical to coverage provided under the Plan to similarly situated individuals.

USERRA continuation coverage is similar to COBRA continuation coverage, but it is not identical, and there are important differences. If you elect both USERRA and COBRA continuation coverage, they will run concurrently. If you elect continuation coverage under both federal laws, you will be provided with the coverage that is most favorable to you. For example, if your COBRA continuation coverage terminates at the end of an 18-month period, you may continue to receive continuation coverage under USERRA up to a total of 24 months. Similarly, if your COBRA continuation coverage terminates before the maximum period because you become covered under another employer's plan, you may continue USERRA continuation coverage up to a total of 24 months.

USERRA continuation coverage terminates when any one of the following events occurs:

(a) The date on which you fail to return from military service to active employment or apply, if applicable, for reemployment as required under USERRA;

(b) The end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

(c) You fail to make a timely payment for your continuation coverage;

(d) The date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

(e) The Participating Employer no longer provides group health coverage to any employees.

To qualify for USERRA continuation coverage, you must provide your employer with advanced notice of your military service, as required under USERRA. You will receive a notice from the Plan Administrator regarding USERRA continuation coverage and an Election Form. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Plan Administrator within the 60-day period identified in the election form. If you fail to return the election form during this time period, you will lose the right to continuation coverage under USERRA. There are limited exceptions when it would

be unreasonable or impossible under the circumstances to provide a timely notice, such as military emergency.

Similar to COBRA, you must pay the entire cost of continuation coverage under USERRA for your coverage and coverage for any dependents. In addition, you will be required to pay a 2 percent administration fee along with each premium payment. The costs of continuation coverage will be identified in the Election Form provided to you by the Plan Administrator. Like COBRA continuation coverage, your initial premium payment(s) must be made within 45 days of your electing USERRA continuation coverage. Subsequent payments must be made on a monthly basis. You will be provided a grace period of 30 days after the first day of the coverage period to make each monthly payment. Failure to pay premium costs before the end of the grace period will result in the loss of continuation coverage.

If your coverage under the Plan is terminated as a result of your service in the uniformed services, your coverage will be reinstated upon your return to active employment under the requirements of USERRA. Your coverage will be reinstated without any preexisting condition exclusions or waiting periods, unless you have an injury or illness incurred during your military service.

Questions concerning your rights to USERRA continuation coverage should be addressed to the Plan Administrator. For more information on your rights under USERRA, contact the nearest office of the Department of Labor Veterans' Employment and Training Service ("VETS") or access the VETS website at www.dol.gov/vets.

In order to protect your and your dependents' rights under USERRA, you should keep the Plan administrator informed of any changes in your or the addresses of family members. You should also keep a copy, for your records, of any notices or form that you send to the Plan Administrator.

6. Patient Protection Disclosure.

The Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health insurance issuer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at (619) 280-2009.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or health insurance issuer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of

participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at (619) 280-2009.

7. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Fund provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/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 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 and/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 in writing at the following address:

Precision Manufacturing Benefits Trust
Coast Benefits, Inc.
3444 Camino Del Rio North, Suite 101
San Diego, CA 92108
(619) 280-2009

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 Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the 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.

8. Privacy of Protected Health Information under HIPAA

This Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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:

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.

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 maybe 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 the Privacy Rule.

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.

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.

Your Individual Rights

HIPAA and the Privacy Rule afford 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 of the Privacy Rule. 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.

Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with 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.

This Plan's Duties

In accordance with the Privacy Rule, 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 the Privacy Rule.
This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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.

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 of Trustees 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 the Privacy Rule.

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.

Duties of the Board of Trustees With Respect to PHI

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

Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer Sandra Eatchel at the following address:

Precision Manufacturing Benefits Trust
Welfare Benefit Plan
c/o Coast Benefits, Inc.
3444 Camino Del Rio North, Suite 101
San Diego, California 92108
(619) 280-2009

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.

Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees 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 Trustees will report to the Plan any security incident of which it becomes aware.

9. 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:

Inadequate or Improper Evidence

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

Coordination of Benefits

If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

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.

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, co-payments.

Failure to Complete Application

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

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 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.

Plan Termination

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