Santa Monica UNITE HERE Health Benefit Plan

SUMMARY PLAN DESCRIPTION

SEPTEMBER 1, 2014

As in Effect On March 23, 2010 and as Amended to Maintain Grandfather Status Under the Affordable Care Act

INTRODUCTION

Dear Eligible Employees:

The Santa Monica UNITE HERE Health Benefit Plan ("the Plan") is maintained by the Santa Monica UNITE HERE Health Benefit Trust Fund ("the Fund") as a multiemployer plan. The Fund was established in 1953, as a result of collective bargaining between employers and the predecessor to UNITE HERE Local No. 11. Employers contribute to the Fund as required by Collective Bargaining Agreements and the Agreement and Declaration Trust Providing for the Fund ("Trust Agreement"). The Board of Trustees of the Fund, appointed by the Union and Employers, design, administer and maintain the Plan.

Under the Plan, eligible Employees and their Dependents are entitled to medical, prescription drug, dental, vision, and life insurance and accidental death and dismemberment benefits. We are pleased to welcome you to our Plan. Please contact our Administrative Office if you have questions or need any assistance.

Sincerely,

BOARD OF TRUSTEES OF THE
Santa Monica UNITE HERE Health Benefit Trust Fund

Administrative Office:

Benefit Programs Administration
13191 Crossroads Pkwy North, Suite 205
City of Industry, California 91746-3434
(866) 345-5189 or (562) 463-5075

Important information, forms, and documents are available on the internet:

www.santamonicauniteherefunds.org

IMPORTANT NOTICE TO EMPLOYEES AND DEPENDENTS

From time to time the Administrative Office may mail you updated material in order to inform you and your Dependents of any changes in benefits. It is important that you file all literature received with this booklet and note the affected sections.

The Trustees have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, and interpret any provisions of the Plan, this Summary Plan Description, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority:

1. To take all actions and make all decisions with respect to eligibility for benefits under the Plan;

2. To formulate, interpret and apply rules and policies to administer the Plan in accordance with its terms; and

3. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents.

In accordance with the terms of the Trust Agreement, the Trustees reserve the right to terminate the Plan, or to amend the Plan, at any time. Such amendments may result in reductions in benefits, or changes in eligibility for benefits. In addition, the Plan may be terminated upon the nonrenewal of all collective bargaining agreements between UNITE HERE Local 11 and employers requiring such employers to make contributions to the Trust Fund.

In the event of any discrepancy or ambiguity, the language of any contract or insurance policy under which Plan benefits are provided will be controlling over any provisions of this Summary Plan Description.

The EHS EPO Plan, the Kaiser HMO Plan and the Prescription Drug Benefits described in this SPD were in effect on March 23, 2010. Amendments effective after March 23, 2010 have been made so as to maintain the status of the Plans as Grandfathered Plans under the Affordable Care Act. Effective January 1, 2015, the Kaiser HMO Plan is no longer a Grandfathered Plan. The descriptions in this SPD include all amendments since March 23, 2010 and effective on or before July 1, 2014.

I. GENERAL DEFINITIONS

When the following terms are used in this booklet, they have the meaning described below:

1. **Dependent.**

   (1) Your legal spouse;

   (2) Your children, including a stepchild, legally adopted child (including a child who has been lawfully placed with you for adoption), or a child for whom you have been appointed legal guardian, who are less than 26 years of age;

   (3) Your Domestic Partner as defined under the Plan;

   (4) children of your Domestic Partner.

2. **Domestic Partner.** A Domestic Partner of the same or opposite sex as an eligible employee may be eligible for benefits under the Plan. To qualify, both the employee and the Domestic Partner must submit a completed Declaration Form, which can be obtained from the Administrative Office. Among other things, the Declaration requires both persons to declare that they are at least 18 years of age, hold themselves out as having a committed relationship, have lived together for at least six months, currently live together and plan to continue living together indefinitely, have had no other spouse or Domestic Partner within the past six months, not be related to a degree that would prevent them from marrying, and have registered their union officially if the jurisdiction in which they live provides for such registration.

   If you wish to enroll a Domestic Partner for benefits, please contact the Administrative Office for an Application, a Declaration of Domestic Partnership Form and further information on enrollment requirements.

3. **Collective Bargaining Agreement**. A labor agreement between the Union and an Employer that requires the Employer to contribute to the Fund, and by which the Employer agrees to be bound by the terms of the Trust Agreement; and any extensions, modifications or renewals of such labor agreement.

4. **Emergency**: Emergency means a sudden onset of a medical condition manifesting itself by severe pain or other acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to place the health of a Employee or Dependent in jeopardy, cause other serious medical consequences, serious impairment to bodily functions, or serious and permanent dysfunction of any bodily organ or part.

5. **Employee**: A person who works in a position that is covered by a Collective Bargaining Agreement.

6. **Employer or Participating Employer.** Any employer that has entered into a Collective Bargaining Agreement or a Participation Agreement.

7. **Fund**. The Santa Monica UNITE HERE Health Benefit Trust Fund.

8. **Hours Worked or Hours.** Each hour worked by or paid to each Employee for which contributions are required under the Collective Bargaining Agreement between the Union and the Employer and actually received by the Fund.

9. **Participation Agreement**. An agreement, other than a Collective Bargaining Agreement, under which an Employer is required to make contributions to the Fund, and agrees to be bound by the terms of the Trust Agreement.

10. **Plan**. The Santa Monica UNITE HERE Health Benefit Plan.

11. **Trust Agreement.** The Agreement and Declaration Trust Providing for the Santa Monica UNITE HERE Health Benefit Trust Fund.

12. **Trustees.** The Trustees of the **UNITE HERE Health Benefit Trust Fund**

13. **Union.** UNITE HERE, Local No. 11, AFL-CIO.

II. ELIGIBILITY RULES

1. HOW YOU BECOME ELIGIBLE
You and your Dependents will become eligible for benefits on the first day of the third month after you have worked for an Employer in a position covered by a Collective Bargaining Agreement for at least 60 Hours in each of the three (3) prior consecutive months **and** the Employer has made the required contributions to the Fund.

For example, if you started work in November and worked at least 60 Hours in each November, December and January, you and your Dependents would become eligible for benefits on April 1.

Other eligibility rules may apply if:

A. You are working for an Employer at the time it signs its first Collective Bargaining Agreement.

B. You were previously eligible under another UNITE HERE Union health and welfare plan.

C. You become disabled before becoming eligible, and your disability is covered by a Participating Employer's Worker's Compensation policy.

Dependents need to be enrolled with the Administrative Office by completing an enrollment card and submitting it along with a marriage certificate (for a spouse), domestic partnership documents, or a birth certificate for eligible children less than 26 years of age. Dependents must be listed on your enrollment card on file at the Administrative Office in order to avoid delays in treatment at the EHS, Kaiser, or United Concordia provider, or at the pharmacy. Notify the Administrative Office promptly of any change in your family status (new children, marriage, divorce, death) or your enrollment in Medicare.

If you have any questions regarding your eligibility or how to obtain your benefits, telephone the Administrative Office of the Health Benefit Plan at (866) 345-5189 or (562) 463-5075

2. INITIAL ENROLLMENT
You will receive enrollment materials from the Administrative Office after you have been reported to the Fund as an Employee. In order to enroll yourself or your Dependents for benefits, you must return your enrollment materials before the first day of the first month on which you (and any Dependents) become eligible for benefits. For example, if you established eligibility in the month of January, you must return the enrollment materials by April 1 in order to be enrolled for the month of April, the first month you are eligible for benefits.

If you do not return the enrollment materials by the first day of your first month of eligibility, your benefits (and benefits for your Dependents) may be delayed.

3. HOW YOUR ELIGIBILITY CONTINUES
Once your eligibility is established, you will remain eligible as long as you continue to have 60 or more Hours Worked each month for one or more Employers, and the Employer or Employers makes contributions to the Fund as required by a Collective Bargaining Agreement. Hours worked during each month determine eligibility for the third following month, as shown in the following Eligibility Table:

ELIGIBILITY TABLE

If You Work 60 or More Hours and Contributions are Made for The Month of	**You Will Be Eligible For Benefits During**

January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

4. WHEN YOUR ELIGIBILITY ENDS

Your eligibility, established under Sections 1 and 3 of this Article II, will end on the last day of the second month after the month in which you worked less than 60 Hours for an Employer making required contributions under a Collective Bargaining Agreement.

For example:

If You Worked Less Than 60 Hours in the Month of	**Your Eligibility and Benefits Will Terminate On**
January	March 31
February	April 30
March	May 31
April	June 30
May	July 31
June	August 31
July	September 30
August	October 31
September	November 30
October	December 31
November	January 31
December	February 28 or 29

You and your dependents may be eligible to continue coverage through COBRA self-payments (Article X) or disability credits (section 8 of this Article II). In addition to these options for continuing coverage under the Plan, you may be eligible to enroll in individual health coverage through a health insurance exchange. You may also be eligible to enroll in Medi-Cal. For more information about those options, visit www.coveredca.com or call (800) 300-1506.

5. HOW YOUR ELIGIBILITY IS REINSTATED

If your eligibility ends, you will re-qualify if you again work 60 or more Hours in one of the four calendar months after the month in which you last worked 60 or more Hours. Your renewed eligibility will start on the first day of the third calendar month following the month in which you again work 60 or more Hours. If you do not work 60 or more Hours in one of the four calendar month periods mentioned above, you must re-qualify as a new employee with 60 or more Hours in each of three consecutive months (see "How You Become Eligible", Article II, section 1).

Examples: End and Reinstatement of Eligibility

A. Maria, an Employee enrolled in the Plan, had 60 or more hours in January, but works less than 60 hours in February and March. She then works at least 60 hours in April.

Result: Maria is eligible for benefits during April because she worked 60 hours or more in January. Maria is not eligible for benefits during May and June, because she did not work 60 hours or more in February and March. Maria is reinstated to be eligible for benefits in July, the third month following April, because she has 60 hours or more in one of the four calendar months (February, March, April, May) after January, the last month that she had 60 hours or more.

B. Franklin, an Employee enrolled in the Plan, had 60 or more hours in December, but he works less than 60 hours from January through April. Franklin returns to working more than 60 hours per month in May, June, July, and August.

Result: Franklin's eligibility ends on the last day of March. Franklin does not have more than 60 hours in any of the four months following December, the last month he had 60 hours or more (January, February, March, April). Therefore, Franklin is required to reestablish eligibility under section 1. Because Franklin has 60 hours or more in three consecutive months (May, June, and July), he is newly eligible for benefits beginning on October 1. In addition, because Franklin works more than 60 hours in August, he will continue to be eligible in November, under section 2.

6. OPEN ENROLLMENT

At least once a year, you will receive notice of the Plan's Open Enrollment period. During Open Enrollment, Employees may make the following changes:

•An Employee who is eligible for benefits, but did not enroll during the initial enrollment period, may enroll during Open Enrollment and may also enroll any Dependents.

•An Employee who did not enroll his or her Dependents during the initial enrollment period may enroll any Dependents.

•An Employee (and his or her Dependents) enrolled in the EHS EPO Plan may enroll in the Kaiser HMO Plan, if the Employee is eligible to elect the Kaiser HMO Plan (see Article III, 1C).

In general, changes made in Open Enrollment become effective on January 1 of the year after the year in which the Open Enrollment period occurs, provided that you continue to be eligible for benefits. Each Open Enrollment announcement from the Fund provides important details, including the dates of the Open Enrollment period.

7. SPECIAL ENROLLMENT

Special Enrollment allows you to enroll yourself or your Dependents outside of Open Enrollment, even if you did not enroll yourself, or your Dependents, in the Plan when you were initially eligible. Special Enrollment is available only in the following circumstances:

•You declined enrollment for yourself or for your Dependents because you or your Dependents had other group health coverage, and you or your Dependents lose eligibility for that coverage (or, in the case of employer-provided group health coverage, the employer stops its contributions toward the cost of the coverage).

Special Enrollment rights apply to loss of eligibility for other group health coverage through divorce or legal separation, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the other coverage), death of an employee, termination of employment, reduction in the number of hours of employment, and exhaustion of COBRA continuation coverage available through another group health plan. Special Enrollment rights do *not* apply to loss of eligibility for other coverage due to failure to pay premiums on a timely basis, or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

In the case of Special Enrollment for loss of eligibility for other coverage, you must request enrollment from the Trust Fund Office within 30 days after the date of loss of eligibility.

•You acquire a new Dependent as a result of marriage or domestic partnership, birth, adoption, or placement for adoption of a child.

In the case of Special Enrollment for marriage or domestic partnership, you must contact the Trust Fund Office to enroll your spouse or domestic partner as a Dependent within 30 days after the marriage or domestic partnership, in order to enroll the spouse or domestic partner as a Dependent effective the first of the month. In the case of Special Enrollment for birth, adoption, or placement for adoption of a child, Dependent coverage will become effective as of the date of the child's birth, or in the case of adoption, the date of adoption or placement for adoption.

•You or your Dependent lose eligibility for coverage under Medi-Cal (or another Medicaid program) or under the State Children's Health Insurance Program coverage (CHIP), or you or your Dependent become eligible for a premium assistance subsidy under Medi-Cal (or another Medicaid program) or CHIP.

In the case of Special Enrollment for loss of eligibility for Medi-Cal or CHIP benefits, you must request enrollment from the Trust Fund within 60 days after the loss of eligibility.

8. EXTENDED ELIGIBILITY FOR DISABILITY CREDIT

If, after becoming eligible you are unable to work 60 Hours a month because of an injury or sickness, as certified by your doctor, you will be given disability credit for each month you are disabled up to four (4) months if the injury or sickness was incurred outside work, or up to six (6) months if the injury or sickness was incurred while working. Disability credit is considered the same as 60 Hours Worked in a month, and will continue your eligibility for the third month after the month for which the credit is given. If you are working for an Employer who employs 50 or more employees when you become disabled, you may qualify under the federal Family Medical Leave Act for extended coverage. Contact your employer or the Administrative Office for more information on the Family Medical Leave Act. COBRA continuation coverage is also available with self-payment. For more details regarding COBRA, see Article X.

9. IF YOU SHOULD DIE

If you should die, the coverage for your Dependents will continue to the end of the period for which you had earned eligibility. They will then be eligible for COBRA continuation coverage by making the appropriate payments.

10. NON-BARGAINED EMPLOYEES

Coverage under the Health Benefit Plan may also be obtained for employees subject to a Participation Agreement but not covered by a Collective Bargaining Agreement, subject to the approval of the Trustees.

11. RESCISSION OF COVERAGE

If you, or your Dependents, make any intentional misrepresentation of facts related to the requirements of this Plan, or eligibility under this Plan; or commit any act of fraud with respect to the Plan, the Plan will rescind coverage for the person making such misrepresentation or committing such fraud. If the Plan rescinds coverage, the result is that the Employee and/or Dependents were never covered under the Plan, and must repay the Plan the full amount paid by the Plan for all benefits provided as a result of misrepresentation or fraud.

III. OUTLINE OF PLAN BENEFITS

1. Medical Benefits

A. For All Employees and their Dependents: EHS EPO Plan. After your eligibility is established, you will be able to enroll yourself and your dependents in the EHS EPO Plan for medical benefits. See the description of the EHS EPO Plan, Article IV of this Summary Plan Description.

> **EHS EPO Plan**: The EHS EPO Plan is provided by Employee Health Systems Medical Group, Inc. ("EHS"). This is an Exclusive Provider Organization (EPO) that requires you to go to a physician, hospital or other medical facility contracted to participate in the EHS network. There are **NO** benefits for out-of-network providers, except for limited benefits for Emergency treatment and certain other preauthorized care. All arrangements for hospitalizations must be made through your EHS medical provider, except in the case of an Emergency, in which case EHS must be called within 24 hours of the Emergency treatment. All Employees and Dependents enrolled in the EHS EPO Plan have access to counseling concerning a wide range of problems under the Members Assistance Program (MAP). The benefits provided under the EHS EPO Plan are subject to the terms and conditions of an agreement between EHS Medical Group, Inc., and the Trust Fund.

B. For Employees with Employers Making Required Contributions, and their Dependents: Kaiser HMO Plan. Once you have been covered under the EHS EPO Plan for at least 6 consecutive months, you may be eligible to choose medical coverage from either EHS or Kaiser Foundation Health Plan during the next Open Enrollment period. To have this choice, your Employer's contribution rate to the Fund must not be less than the minimum amount per hour as established by the Trustees.

> **Kaiser HMO Plan**: The Kaiser HMO Plan is provided through the Kaiser Foundation Health Plan. In order to enroll in the Kaiser HMO Plan, you must be eligible for the Kaiser HMO Plan and also live within 30 miles of a Kaiser Permanente medical group or facility. Under the Kaiser HMO Plan, most covered services will be provided at no charge or will require a small copayment. In general, no benefits are payable for services provided outside the Kaiser HMO network, except in case of Emergency. The services covered, any copayments, the conditions or circumstances under which services may be received or denied, and details on the procedures to be followed for obtaining these services and/or for the review of claims for services which are denied, in whole or in part, are explained in a separate booklet printed by Kaiser. The booklet will be provided to you by the Administrative Office if you elect to enroll in Kaiser.
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> When you enroll in Kaiser, you must receive services at facilities associated with Kaiser Permanente. A list of Kaiser facilities will be provided to you by the Administrative Office. If you do not receive services at Kaiser authorized facilities, you will be responsible for 100% of the charges (except in the case of an Emergency, in which case Kaiser will determine how much it will pay). The benefits provided by Kaiser are subject to the terms and conditions of an agreement with the Health Benefit Plan.

C. Making the Choice between EHS and Kaiser: If you have a choice of the EHS EPO Plan or the Kaiser HMO Plan, you should make your selection carefully because you will only be allowed to change your selection once per year, during open enrollment (see Article II, section 6). The two plans are different. For example, under the Kaiser HMO Plan you will pay a $15 copay for a doctor visit, but under the EHS EPO Plan there is no cost for doctor visits. If you select EHS, you are limited to $75,000 of hospital coverage per illness or accident. The Kaiser HMO Plan does not have a limit on hospital coverage. If you select Kaiser, you must use Kaiser providers and if you select the EHS EPO Plan, you must use EHS providers. EHS limits benefits for Emergency services received outside the EHS EPO network to $15,000, but Kaiser has no similar limit on benefits for Emergency services outside the Kaiser HMO Network.

You will receive a Summary of Benefits and Coverage for the Kaiser HMO Plan and for the EHS EPO Plan that further describes each Plan.

D. Open Enrollment. Employees who are eligible to choose between the EHS EPO Plan or the Kaiser HMO Plan may make their choice only during Open Enrollment (see Article II, section 6). Open Enrollment is conducted each year, usually during November – December. In addition to enrollment of Employees and Dependents, as described in Article II, choice of medical benefit plan must be submitted in writing to the Trust Fund Office, prior to the end of the Open Enrollment period. Changes made in Open Enrollment become effective January 1 of the year following the Open Enrollment period. The choice you make during Open enrollment cannot be changed until the next Open Enrollment.

2. Prescription Drug Benefits

The prescription drug plan described in this SPD is provided by Express Scripts for all eligible Employees and Dependents. You have the same Express Scripts prescription drug benefits whether you are enrolled in the EHS EPO Plan or in the Kaiser HMO Plan. You must use a pharmacy contracted with Express Scripts to fill your prescription. A list of Express Scripts network pharmacies will be provided to you upon request, without charge. The Express Scripts prescription drug plan is described in Article VI.

3. Dental Benefits

All Employees and Dependents have the same dental benefits, whether enrolled in the EHS EPO Plan or in the Kaiser HMO Plan. Dental benefits are provided by the United Concordia Pre-Paid Dental Plan when you use a United Concordia dentist. Benefits are described in a separate booklet, which will be provided to you by the Administrative Office and in Article VII. A list of the United Concordia Pre-Paid Dental Plan Providers will also be provided to you by the Administrative Office.

4. Vision Benefits

All Employees and Dependents enrolled in the EHS EPO Plan have Vision Benefits provided by EHS Medical Group. Those benefits are described in Article IV-E. Employees and Dependents enrolled in the Kaiser HMO Plan have Vision Benefits provided by Kaiser. Those benefits are described in documents provided by Kaiser.

5. Life Insurance and Accidental Death and Dismemberment Benefits

Life Insurance and Accidental Death and Dismemberment Benefits are provided on a self-funded basis as described in Articles VII and VIII.

IV. EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP EPO PLAN
(Must Use EHS Approved Facilities)

Internet (information about EHS providers and facilities)
http://www.ehsmd.com/unions/members/

24-HOUR HOTLINE TELEPHONE NUMBERS:
(310) 641-1997 OR (800) 231-1407

1. About the EHS EPO Plan
The EHS EPO ("Exclusive Provider Organization") Plan, is offered by Employee Health Systems Medical Group, Inc. In general, the EHS EPO Plan provides benefits only for medical services that are performed or referred by EHS Providers, meaning a physician, nurse, or other medical professional at an EHS clinic, hospital, or other facility contracted with EHS. Specific exceptions apply for medical care in case of Emergency, covered as described in Article IV-B, below; and medical care not available through EHS, covered as described under Article IV-A.

2. Physician's Office Appointments
You may select an EHS Physician from the list of Primary Care Physicians for Union Members (on the EHS Web site) as your personal EHS physician. However, you are not required to select a personal EHS physician in order to make an appointment with a physician. Please call at least 48 hours in advance for routine, non-emergency appointments, and two or three weeks in advance for annual health evaluations.

3. Same Day Appointments/Urgent Care Services
If you have a sudden illness, pain, severe coughing or other illness or injury requiring immediate attention and your personal EHS physician is unavailable, an appointment may be made with another doctor in the EHS Medical Group System. Walk-in patients at regular EHS medical offices will be seen as soon as possible according to the urgency of their complaint. However, walk-in services are discouraged and all members are requested to call in advance for appointments whenever possible.

You may also use the walk-in and urgent care services at an EHS Medical Group Urgent Care Facility.

In order to find an EHS Medical Group Urgent Care Facility, visit http://www.ehsmd.com/ unions/members/urgent-care/ or call EHS at 310-641-1997 or 800-231-1407.

No copayment is required at regular EHS medical offices or EHS Urgent Care Facilities.

4. Hospital Services
EHS offers Contracted Hospitals for Employees and Dependents in Southern California. In order to find an EHS Contracted Hospital, or to confirm that the hospital you are using, or planning to use, is an EHS Contracted Hospital, visit http://www.ehsmd.com/unions/members/hospitals/ or call EHS at 310-641-1997 or 800-231-1407.

5.MEDICAL BENEFITS
The EHS EPO Plan covers most medical services in full. Some services may require you to pay a copayment and/or coinsurance. The Schedule of Benefits outlines the services and the copayments and/or coinsurance, if any.

A. Preauthorization for Services by Specialists

The Plan will not pay for the services of specialists, unless such services are preauthorized by EHS in writing.

B. Deductible
There is no deductible under the Plan, except a $50 deductible for out-of-network Emergency services.

C. Benefit Maximums and Limitations

The Plan will cover hospitalization up to $75,000 per illness or accident. There are also limitations on services received for Emergency care.

IV-A. EHS EPO PLAN SCHEDULE OF BENEFITS

EHS EPO Plan provides services by family practitioners (EHS personal physicians) as well as necessary specialists and consultants as described below. Please see Article IV-C for the Principal Exclusions and Limitations on Benefits.

The Plan will not pay for the services of specialists, unless such services are preauthorized by EHS in writing.

BENEFIT	EMPLOYEE/DEPENDENT PAYS
A. DOCTOR'S OFFICE VISIT No limit, including specialists.	No charge. Covered in full.
B. DOCTORS' HOSPITAL VISITS In EHS approved hospital, including specialists.	No charge. Covered in full.
C. X-RAYS AND LABORATORY TESTS For diagnostic purposes. Must be preauthorized by EHS.	No charge. Covered in full.
D. IMAGING (CT/PET SCANS, MRIS) For diagnostic purposes. Must be preauthorized by EHS.	No charge. Covered in full.
E. URGENT CARE (See description on page 14) Only at EHS Urgent Care Clinics	No charge. Covered in full.
F. INJECTABLE MEDICATION Including allergy antigen, vaccinations and immunizations.	No charge. Covered in full.
G. ALLERGY TESTING SERIES, MEDICATION	No charge. Covered in full.
H. RADIATION, COBALT & RADIOISOTOPE THERAPY	No charge. Covered in full.
I. PHYSICAL, SPEECH & OCCUPATIONAL THERAPY For conditions determined by an EHS physician to be subject to significant improvement through such therapy within sixty (60) days if provided at an EHS Medical Group Clinic and within six (6) visits if provided elsewhere. (See Exclusions and Limitations).	No charge. Covered in full.
J. REHABILITATION SERVICES For inpatient hospital or licensed rehabilitation facility as prescribed and authorized by a contracted EHS physician to allow the patient to reasonably reach their maximum physical potential following any disease or traumatic occurrence. The member is entitled to sixty (60) days per calendar year.	15% coinsurance based on EHS contracted allowable rates.
K. PODIATRY SERVICES Services of a podiatrist when authorized by EHS.	No charge for visit with EHS referral. Specialized supplies will be billed to patient at EHS's actual cost, plus 5%.
L. PREVENTIVE HEALTH SERVICES Elective annual physical examinations including x-rays and laboratory tests, well baby care, pediatric and adult immunizations and periodic Papanicolaou (pap) tests.	No charge. Covered in full. (For school and/or employment physicals, etc. there may be a charge for completion of health statement.)
M. DRUG AND ALCOHOL DEPENDENCY TREATMENT The treatment of drug and/or alcohol dependency, including detoxification, in appropriately licensed and EHS-contracted facility\ Preauthorization required.	*Outpatient Services:* No charge. Covered in full. *Inpatient Services:* Covered in full, subject to limit of $75,000 per accident or illness..

BENEFIT	EMPLOYEE/DEPENDENT PAYS
N. OUTPATIENT MENTAL HEALTH/MARRIAGE FAMILY COUNSELING Outpatient visits to a mental health professional including marriage/family counseling when referred by an EHS Primary Care Physician.	No charge. Covered in full.
O. EMERGENCY ROOM SERVICES – EHS CONTRACTED PROVIDER	No charge. Covered in full
P. EMERGENCY TREATMENT at an EHS-CONTRACTED HOSPITAL	No charge. Covered in full, subject to limit of $75,000 per accident or illness
Q. EMERGENCY TREATMENT at a NON-EHS-CONTRACTED EMERGENCY ROOM AND HOSPITAL	Significant Charges due to Limited coverage. See Article IV-B, 1-2.
R. SURGICAL BENEFITS Surgeon, assistant surgeon and anesthesiologist; includes reconstructive surgery after mastectomy (on the affected breast and on the other breast to produce a symmetrical appearance, as determined by the physician and patient); includes other reconstructive surgery that is medically necessary.	No charge. Covered in full.
S. HOSPITAL BENEFITS All hospitalizations, except Emergency and childbirth, require pre-authorization by EHS or no coverage. Charges, when authorized in advance by EHS, for inpatient care. Covered charges include: room and board in a semi-private room (where available), including intensive and cardiac care units, general nursing care, special duty nursing, meals and special diets. Diagnostic laboratory and x-ray services. Use of operating room and related facilities. Miscellaneous hospital charges for necessary care and treatment.	No charge, covered in full, up to maximum benefit for hospitalization at EHS-Contracted Hospital of $75,000 per accident or illness. No coverage for the same accident or illness after the maximum benefit is paid. After the maximum, Employee pays 100% of EHS Contract Rate with the hospital.
T. AMBULANCE SERVICES	15% coinsurance.
U. FAMILY PLANNING BENEFITS (available only to Employee and legal spouse or domestic partner of Employee).	
Intra uterine device insertion	$60 copayment
Vasectomy (male sterilization)	$200 copayment
Tubal ligation (female sterilization)	$400 copayment
Induced interruption of pregnancy (not medically necessary)	$200 copayment
Therapeutic abortion (medically necessary)	Covered same as any other condition.
V. CHILDBIRTH BENEFITS (Maternity care is available only to eligible Employees or the legal spouse or domestic partner of Employees) EHS Medical Group physician and hospital, including pregnancy complications and physicians' care of mother and newborn at EHS hospital.	No charge. Covered in full.

BENEFIT	EMPLOYEE/DEPENDENT PAYS
Under federal law, benefits may not be restricted 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, the Plan may not, under federal law, require that EHS obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).	
W. HEALTH EDUCATION SERVICES Instruction in personal health care measures, information about EHS Services.	No charge. Covered in full.
X. OUTPATIENT HOSPITAL SERVICES Outpatient surgery in a hospital, ambulatory surgical center, or similar facility. *Requires pre-authorization by EHS or no coverage*.	No charge. Covered in full.
Y. HOME HEALTH CARE Services provided in the home of an Employee or Dependent, where medically necessary and preauthorized by an EHS physician. Services include diagnostic and treatment services which can reasonably be provided in the home, performed by a licensed nurse, aide or therapist, and provided by an EHS-contracted home health agency. This benefit does not cover custodial care. Employee or Dependent is entitled to sixty (60) home health visits per calendar year.	15% coinsurance, based on EHS contracted allowable rates.
Z. CHIROPRACTIC SERVICES Chiropractic Services are provided exclusively through: Culver Medical Center Bridgitte Rozenburg DC 12568 W. Washington #202 Culver City, CA 90066 (310- 842-9113 15710 ½ Vanowen St Van Nuys, CA 91406 (818- 901-1505	$5 copayment for up to 15 visits per calendar year. Additional visits past 15 per calendar year are provided at a $25 copayment per visit.
AA. HEARING AID Limited to one (1) hearing aid per ear every two years. The benefit covers the following when authorized in advance: basic behind-the-ear or in-ear unit, diagnostic procedures (professional services) for testing and hearing aid assessment. Professional service fee(s) include adjustments, hearing aid orientation, post-fitting and follow-up visits directly related to hearing aid dispensing. If the Employee or Dependent elects to upgrade unit or obtains other non-covered services he shall be responsible for remainder of the total charge with a 20% discount off of usual and customary charges. Discount will be based on the type of unit model selected.	EHS Provider: $25 copay for covered services and devices. Non-EHS Provider: Maximum benefit of $500 minus $25 deductible.

BENEFIT	EMPLOYEE/DEPENDENT PAYS
BB. Referral to Non-Contracted Hospital Injuries and Illnesses for which treatment is not available at EHS Contracted hospital, that are not emergencies, and that EHS refers to a Non-Contracted Hospital	Maximum reimbursement of $750.00 per day, up to a maximum benefit of $10,000.00

URGENT CARE TREATMENT

If you or a Dependent have a sudden illness, pain, severe coughing or other illness or injury requiring immediate attention:

1. Call the 24-Hour Emergency number **(310) 641-1997 OR (800) 231-1407** or the office number for your EHS facility and inform them that you are a EHS member and give them the name of your personal EHS Physician, if you have chosen one.

2. State "this is an emergency" and describe your condition.

3. Follow first aid instructions, if any.

4. If advised, go to an EHS Contracted Hospital, EHS Urgent Care Facility, other EHS facility, or Emergency Room.

You may also use the walk-in and urgent care services available through an EHS Medical Group Urgent Care Facility.

Examples of urgent care situations include:

1. Sprains, strains
2. Bad cuts or wounds
3. Broken bones
4. Minor burns
5. Excessive vomiting
6. Severe stomach pain
7. Prolonged diarrhea
8. Swollen glands
9. High fever
10. Rashes, poison ivy

If you need urgent care when you are outside of Los Angeles or Orange Counties:

1. Go to the nearest urgent care facility, hospital, or physician for treatment.

2. Notify EHS Medical Group immediately to verify benefits for the services. Your physician may arrange to transfer you to a participating hospital as soon as medically feasible.

IV-B. EMERGENCY TREATMENT AND BENEFITS UNDER EHS EPO PLAN

1. EMERGENCY

Emergency is defined as the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including sudden and unexpected severe pain) that without immediate medical attention could reasonably result in any of the following: (a) placing the patients' health in serious jeopardy, (b) serious impairment to bodily functions, (c) other serious medical consequences, or (d) serious and/or permanent dysfunction of any bodily organ or part.

Medical Emergencies include:

1. Heart attack symptoms such as chest pains
2. Major burns
3. Serious breathing difficulties
4. Shock
5. Spinal injuries
6. Unconsciousness
7. Uncontrolled bleeding
8. Poisoning

2. WHAT TO DO IN AN EMERGENCY

In Emergencies, call the paramedics or go to the nearest hospital emergency room immediately. ALWAYS NOTIFY EHS MEDICAL GROUP AS SOON AS POSSIBLE WITHIN 24 HOURS.

If you are involved in an accident and have no control over where you are taken following the accident, always **notify EHS as soon as possible, within 24 hours.**

3. EMERGENCY BENEFITS AND RATE SCHEDULE

a. **Treatment at an EHS-contracted facility**. All Emergencies treated at an EHS approved facility shall be payable at Plan benefit rates, subject to the limitation on Hospital Benefits (See IV-A, O and P).

b. **Treatment at a non-EHS-contracted facility**. The following benefit payment limits apply to Emergency services rendered within the United States in non-EHS Hospitals.

(i) Emergency services in non-EHS Hospitals will be reimbursed as follows:

Hospital Per Diem	$580.00
Hospital ICU or CCU	$740.00
Surgical - value per unit	$132.00 (1974 CRVS)
Medicine - value per unit	$5.50 (1974 CRVS)
Lab - value per unit (includes professional component)	$1.10 (1974 CRVS)
X-Ray - value per unit (includes professional component)	$11.00 (1974 CRVS)
Anesthesia - value per unit	$28.00 (1974 CRVS)

(ii) Deductible for Emergency Room:

Employee or Dependent pays first $50 of covered emergency room charges

where Employee or Dependent is not admitted into an acute care hospital as an inpatient.

(iii) Maximum payable for Emergency Room charges is $3,000, after $50 deductible.

(iv) Total maximum payable (inclusive of Emergency Room charges and Emergency services under (i) is $15,000 in total payments in non-EHS facilities for each occurrence.

Limitations: EHS must be notified within 24 hours of any hospital admission and has the right to transfer the member to a contracted facility based on the member's condition and sound medical judgment. The Employee or Dependent is entitled to out-of-area Emergency care only when temporarily traveling out of Los Angeles or Orange Counties. For services within Los Angeles or Orange Counties, the patient must have a life-threatening Emergency to be eligible for a benefit at a non-EHS contracted facility.

2. Emergencies Outside the 50 United States:

The following Emergency benefits will apply to Employees or Dependents who are temporarily away from their home and outside the 50 United States (plus the District of Columbia):

a. Hospital charges - maximum benefit is $250.00
Professional services - maximum benefit is $150.00

b. No copayment required.

IV-C. PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS

EXCLUSIONS AND LIMITATIONS:
The following conditions, services and products are not covered by the EHS Plan:

1. All physician and hospital services, except in Emergencies (see description of Emergency benefits set forth above), which are not authorized by an attending EHS Medical Group physician and all treatment not specified under Description of Covered Services, Article IV-A.

2. Treatment or services that are not Medically Necessary. Treatment or service is medically necessary only if it is determined to be:

    a. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;
    b. Provided for the diagnosis or direct care and treatment of the medical condition;
    c. Within standards of good medical practice within the organized medical community;
    d. Not furnished primarily for the convenience of the Employee or Dependent, the attending physician or other provider of services; and
    e. The most appropriate supply or level of service which can safely be provided.

3. Out-of-network services (other than Emergency services) are subject to the following limitations:

    a. Without preauthorization, no benefits are payable for out-of-network services other than in case of Emergency.

    b. With preauthorization, benefits for non-emergency out-of-network services are limited to a maximum benefit of $10,000 per accident or illness.

    c. Charges are reimbursable only up to $750 per day for outpatient surgical facility or inpatient hospitalization.

4. Cosmetic surgery, unless determined to be medically necessary by EHS.

    The following services are covered when a mastectomy has been performed:

    a. reconstruction of the breast on which the mastectomy has been performed;

    b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

5. Experimental medical, surgical or other health care procedures and products.

6. Acupuncture services.

7. Bariatric Surgery and weight loss programs.

8. Private-duty nursing and skilled nursing care.

9. Long term rehabilitation care, including physiotherapy and special educational programs for developmental disabilities. (Long term is defined as more than 60 continuous days per illness or injury if treatment can be provided at a EHS Medical Group clinic, and more than six (6) visits per illness or injury if treatment must be provided elsewhere.)

10. Custodial, domiciliary or rest home care, or long term care, long term hospital, skilled nursing home, or intermediate care, except as provided under the Schedule of Benefits.

11. Hospice services.

12. Habilitation services.

13. Infertility treatment.

14. Intersex surgery (trans-sexual) operations or complications arising therefrom.

15. House calls by a physician.

16. Private hospital rooms, unless determined by EHS Medical Group to be medically necessary.

17. Whole blood, plasma and specially processed derivatives.

18. Blood bank fee.

19. Personal or comfort aids.

20. Dental services and oral surgery. (See Article VII for description of dental coverage provided through United Concordia.)

21. Drugs, medications, prescriptions, supplies for outpatient care. (Prescription Drug Benefit is provided through Express Scripts, Article VI).

22. Professional services or materials connected with lost or stolen hearing aids or accessories such as batteries, cords, etc.

23. Artificial aids, corrective appliances or take home supplies and durable equipment, except as provided for a mastectomy.

24. Any services or supplies which are provided by or payable under any plan or law of any Government (Federal or State, Dominion or Provincial) or its political subdivisions.

25. Any services covered by Workers' Compensation or occupational disease law.

26. Any medical service provided outside the 50 United States (plus the District of Columbia), except as stated under Emergencies Outside the 50 United States.

27. Injuries or sickness resulting from participation in any unlawful act, unless the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions); except as provided under the Members Assistance Program (MAP).

IV-D. OTHER BENEFITS AND THIRD-PARTY PAYMENTS

In the event that an Employee or Dependent receives services covered under the EHS EPO Plan while covered under other group health coverage that also provides coverage for such services, the following coordination of benefits rules shall apply:

a. In the case of an Employee, the EHS EPO Plan shall be primary, unless the Employee has had other coverage for longer than the EHS EPO Plan.
b. In the case of a Dependent covered under other group health coverage provided by such Dependent's employer, the EHS EPO Plan shall be secondary. The EHS EPO Plan will pay the amount, if any, by which the benefit for such service under the EHS EPO Plan exceeds the benefit for such service under the other group health coverage.

In addition, in order to receive hospital, medical and surgical care from EHS Medical Group, Employees or Dependents who suffer injury from a third party who is liable for the cost of hospital, medical, or surgical services, must assign to EHS the cost of hospital, medical, or surgical services provided by EHS in treating the injury in an amount not to exceed that paid by such third party.

IV-E. VISION BENEFITS PROVIDED THROUGH EHS MEDICAL GROUP

Vision care benefits are provided as part of the EHS EPO Plan. This benefit is only available for employees and their Dependents who are covered under the EHS medical plan.

Call for an appointment at (310) 641-1997 or (800) 231-1407.

Examinations, lenses and frames are provided without charge as follows:

Vision Examination:	Every 12 months
Eyeglass Lenses:	Every 24 months, only if needed
Frames:	Every 24 months, only if needed

Contact Lenses
An Employee or Dependent may choose contact lenses in lieu of eyeglasses. For contact lenses, there will be a $20 deductible, after which EHS will pay a maximum of $100 per calendar year.

LIMITATIONS AND EXCLUSIONS

Extra Cost
The plan is designed to cover your visual needs rather than cosmetic materials. There will be an extra charge for any of the following:

1. blended lenses;
2. oversize lenses;
3. progressive multifocal lenses;
4. photochromic lenses or tinted lenses other than Pink #1 or #2;
5. coated lenses;
6. laminated lenses; or
7. a frame that costs more than the plan allowance.

Please contact the EHS Medical Group to inquire about the Plan allowance for frames and lenses.

Not Covered
There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemented testing.

2. Plano lenses.

3. Two pair of glasses in lieu of bifocals.

4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal 24-month interval for Eyeglass Lenses.

IV-F. MEMBERS ASSISTANCE PROGRAM (MAP)

Telephone: 1-(888) 475-1997

The EHS EPO Plan Members Assistance Program (MAP) provides three (3) free and confidential counseling sessions per year for Employees and Dependents covered under the EHS medical plan.

It is the intent of the Trustees to provide you and your Dependents with a service that consists of confidential* counseling, consulting, and referral services in a broad range of areas, such as:

- Work problems
- Family problems
- Stress
- Parenting problems
- Problems with Supervisors
- Self-esteem
- Anxiety
- Fatigue
- Divorce and separation
- Physical Abuse
- Communication difficulties
- Depression
- Aging Parents
- Life changes
- Illness or disability

MAP provides confidential assessment and help for chemical dependency problems and assistance in finding treatment for members. MAP can also offer a variety of counseling in areas such as; job stress, handling conflict, dealing with change, dealing with difficult customers, assertiveness, job uncertainty, communication skills, team building, or alcohol and drug awareness.

MAP services are completely voluntary and confidential*. Nothing you say is discussed without your specific permission. Members Assistance Program is through:

Employee Health Systems
1600 Corporate Center Dr.
Monterey Park, California 91754

For more information or an appointment, call the Members Assistance Program at (888) 475-1997.

* Patient's statements may not be held private if the patient is dangerous to self or others or describes child or elder abuse.

IV-G. MAKING CLAIMS FOR BENEFITS and FILING APPEALS AND REPORTING COMPLAINTS

If you have a question or problem regarding any of the benefits or services, or you believe you were wrongly denied benefits or services, under the EHS EPO Plan, you may file a form at any EHS participating facility, or you may call or write the Medical Director at EHS Medical Group:

EHS Medical Group
1600 Corporate Center Dr.
Monterey Park, California 91754
(310) 641-1997 or (800) 231-1407

If you are referred by EHS to a hospital or another outside physician and you later receive a billing for those services, you should immediately advise EHS Medical Group at the above address.

You may authorize a representative to act on your behalf in making a claim for benefits, reporting a complaint, or appealing the denial of a benefit under the EHS EPO Plan.

MAKING A CLAIM FOR BENEFITS

In most cases, your EHS personal physician, or other EHS medical personnel, will provide care directly, or preauthorize necessary care. However, EHS maintains procedures for you to file a claim if you believe that you require certain care, or if you receive care out of network.

In addition, EHS is required to meet certain deadlines in responding to claims for services. In general, EHS must respond within 15 days, in the case of claims for preauthorization of services; within 30 days, in the case of claims for services; but within 72 hours in the case of claims identified as urgent care claims. *Urgent care* claims are claims for preauthorization or for services where lack of a rapid response could seriously jeopardize your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Claims during Urgent Care and Emergency. In the case of a claim involving urgent care, EHS will notify you of the decision on your claim for benefits as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. However, if you do not provide sufficient information to determine whether, or to what extent, the benefits in question are covered or payable under the EHS EPO Plan, within 24 hours after receipt of the claim EHS will inform you of the specific information necessary to complete the claim. You will be given a reasonable amount of time, but not less than 48 hours, to provide the necessary information. EHS will notify you of the benefit determination as soon as possible, but in no case later than 72 hours after receipt of your appeal or complaint, or 48 hours after the receipt of information requested by EHS.

Concurrent Care: Change in Treatment Plan. If you have been approved for an ongoing course of treatment to be provided over a period of time or number of treatments, EHS will notify you of any reduction or termination in such course of treatment before the end of the period of time or number of treatments originally approved. EHS will notify you at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Concurrent Care: Expansion of Treatment Plan. You may request that EHS extend the course of treatment beyond the period of time or number of treatments originally specified. In the case of a claim involving urgent care, your request will be decided as soon as possible, taking into account the medical exigencies, and you will receive notice of the benefit determination within 24 hours after receipt of your

request. In other cases, your request for extension will be considered as a non-urgent appeal.

Claims related to Preauthorization. In the case of a preauthorization request, EHS will notify you of its benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for preauthorization. This period may be extended one time for up to 15 days. In case of such an extension, EHS will notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which EHS expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

Claims not related to Preauthorization or Urgent Care. If your claim does not relate to preauthorization for treatment or services, as, for example, in the case of a claim for benefits related to services you have already received, EHS will notify you if your claim is denied within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days. If such an extension is necessary because you did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

APPEALS AND COMPLAINTS

Once you receive notice that your claim for benefits is denied, you have 180 days to appeal to EHS.

You may submit written comments, documents, records, and other information relating to your claim for benefits to EHS. In addition, EHS will provide you with copies of all documents, records, and other information relevant to your claim for benefits, including all documents submitted, considered, or generated in the course of making the benefit determination, as well as any statement of policy or guidance with respect to the plan concerning the denied benefits, upon request and free of charge. In addition, EHS will identify any medical or vocational experts whose advice was obtained in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In reviewing your appeal or complaint, EHS will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted or considered in the initial benefit determination.

Your appeal or complaint will be reviewed by one or more individuals who are neither the individual who made the adverse benefit determination on your claim, nor a subordinate of such individual.

In deciding an appeal of any denial that is based on a medical judgment, including determinations whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, EHS shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional consulted for this purpose shall not be an individual who was previously consulted in connection with the claim that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim involving urgent care, you may request an expedited appeal orally or in writing; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant electronically, by telephone, facsimile, or other available similarly expeditious method.

Notification of Decision on Appeal. In general, you will receive notice of the decision on your appeal within a reasonable period of time, but not later than 60 days after receipt of your appeal or complaint submission. If EHS determines that an extension of time is required, you will be given written notice of the extension prior to the termination of the initial 60-day period. The extension notice shall indicate the circumstances requiring an extension of time, and the date by which your appeal is expected to be

decided.

If your appeal is denied, the notice of such denial shall contain the following information:

(1) The specific reason or reasons for the denial;

(2) Reference to the specific plan provisions on which the decision is based;

(3) A description of your rights to further appeal and/or legal action against the Plan;

(4) A statement or description of any rule, guideline, protocol, or other similar criterion relied upon in deciding the appeal, and a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request;

(5) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(6) The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

For other rules related to appeals under the Santa Monica UNITE HERE Health Benefit Plan, see Article XII of the Plan.

V.KAISER HMO PLAN

The benefits and rules of the Kaiser HMO Plan are described in the Kaiser Permanente Evidence of Coverage. The Evidence of Coverage, provided to Employees who enroll in the Kaiser HMO Plan and their Dependents, describes the medical and vision benefits, and the copayments and other requirements of the Kaiser HMO Plan.

The Kaiser Permanente Evidence of Coverage is part of this Summary Plan Description. It will be furnished to you separately if you are enrolled in the Kaiser HMO Plan.

Important information about the Kaiser HMO Plan is also available in the Summary of Benefits and Coverage, available from the Administrative Office.

VI. PRESCRIPTION DRUG PLAN PROVIDED THROUGH EXPRESS SCRIPTS

The Plan contracts with Express Scripts to provide prescription drugs for you and your Dependents.

Prescriptions must be filled at pharmacies contracted with Express Scripts in order to be covered by the Plan. A list of contracted pharmacies in your area can be found on the Express Scripts Web site, http://www.express-scripts.com. Any prescription obtained through a pharmacy not contracted with Express Scripts will not be covered, except in case of an Emergency.

Retail Pharmacy Program

IMPORTANT: If you are taking a maintenance drug (one taken for more than 45 days) you must use the mail order Express Scripts Select Home Delivery program after the second refill at the retail pharmacy, unless you contact Express Scripts and Express Scripts grants permission for subsequent refills at a retail pharmacy.

To ensure proper use of certain drugs, some medications will now require prior authorization before they can be filled. If prior authorization is needed, your doctor or the pharmacy may contact Express Scripts to determine if the prescription meets the guidelines established for Fund benefits.

To have your prescription filled at a retail pharmacy, you must do the following:

1. Go to your neighborhood chain store pharmacy (such as CVS or Rite Aid) or any other pharmacy contracted with Express Scripts under their Select Network. The Express Scripts Web site, http://www.express-scripts.com, provides more information about Express Scripts contracted pharmacies.

2. Identify yourself as eligible for prescription benefits by presenting your Express Scripts identification card to the pharmacist. The Plan covers only you and your Dependents as listed on your card.

3. The pharmacist will verify your eligibility with Express Scripts.

4. The pharmacist may also contact Express Scripts regarding prior authorization. If this occurs after normal business hours, you may have to wait until the next business day for your prescription.

5. If the prescription is required immediately, you may pay for the prescription and submit a direct reimbursement claim form.

7. In accordance with your drug benefit program, for drugs purchased at a retail pharmacy your copayment per prescription is:

   Retail: (limit 30-day supply)

   Generic drugs - $3.00 copayment.
   Brand name drugs - $6.00 copayment

   The pharmacist will provide generic drug substitution wherever available and allowed by a physician. The pharmacist will inform you when a generic substitution has been made. If you do not wish generic substitution, or if your doctor orders a brand name drug to be dispensed as written when there is a generic equivalent, the brand name product will be dispensed, but you will

have to pay the full difference in cost between the name brand and the generic drug, plus the applicable copayment.

Mail Order Pharmacy Program

If you are on maintenance drugs (drugs that you expect to take regularly over a period of 45 days or more) you must use the mail order plan. Your Mail Order Prescription Benefit is provided through the Express Scripts Select Home Delivery program. The Express Scripts Select Home Delivery program was designed to allow members to receive larger quantities of maintenance medication (e.g. heart medication, blood pressure medication, diabetes medication, etc.).

When you are first prescribed a maintenance drug, you may fill the initial prescription, and one refill, at a local contracted pharmacy. Thereafter, unless Express Scripts agrees to continued use of a local pharmacy, you must use the Express Scripts Select Home Delivery program. In order to do so, you or your doctor must send your prescription to Express Scripts. You may call the Administrative Office for additional information and order forms, or log in to http://www.express-scripts.com..

Your copayment when purchasing maintenance drugs through mail order will be:

Mail Order: (90-day supply)

Generic drugs - $3.00 copayment
Brand name drugs - $5.00 copayment

You can obtain up to a **90 day supply** of your prescription, if your doctor prescribes this quantity. Your cost is limited to the copayment, unless your physician prohibits generic substitution (a "dispense as written" prescription), or you choose a brand name drug instead of a generic equivalent. In these cases you will be responsible for the cost difference between the brand name drug and its generic equivalent.

You must obtain a new prescription from your doctor when your prescription expires, in order to continue receiving maintenance drugs through the Express Scripts Select Home Delivery program. Call your doctor promptly to assure that you have the new prescription when you need it. In general, you must send renewal prescription(s) to Express Scripts fifteen (15) days before you need them to receive the prescription before your prior prescription or refill runs out. After the first order, if your prescription includes refills, you can order your refills by telephone.

COVERED ITEMS:

- Federal Legend drugs
- State Restricted drugs
- Compounded prescriptions
- Insulin
- Federal Legend Non-Drugs
- Syringes, Needles and Devices
- Accutane, through age 24 only
- Tretinoin, ages 19 through 24 only

SPECIAL RULES FOR COMPOUND DRUGS:

For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. That list may be obtained from Express Scripts. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered reasonable. Any denial of coverage a

compound drug may be appealed in the same manner as any other drug claim denial under the Plan.

EXCLUSIONS:

- •Non-Federal Legend Drugs, Non-Federal Legend Non-Drugs
- •Durable Medical Equipment
- •Hemopoetic Agents
- •Nicotine Patches
- •Abortifacients (including Mifeprex)
- •Accutane (above age 24)
- •Depigmentation Agents
- •Injectable Cosmetics
- •Legend Hair Growth Agents
- •Contraceptive Devices, Contraceptive Implants, IUD
- •Impotence – Yohimbine
- •Fertility Regulators
- •Growth Promoting Agents
- •Botox
- •Allergens
- •Serums, Toxoids, Vaccines
- •Prescriptions covered without charge under Federal, State, or Local programs, to include Worker's Compensation
- •Any charge for the administration of a drug or Insulin
- •Investigational or experimental drugs
- •Unauthorized refills
- •Medication while confined in a hospital, rest home, nursing home, sanitarium, extended care facility, or similar entity
- •Any item for which the usual and customary charge is less than the copayment under the Plan
- •Any charge above the usual and customary, advertised or posted price, whichever is less than the scheduled amount

VII. DENTAL CARE PLAN THROUGH UNITED CONCORDIA

Your dental care is provided through United Concordia. This benefit is available for all Employees and their Dependents.

The benefits and rules of the Dental Care Plan through United Concordia Dental are described in the Evidence of Coverage and Disclosure Form and the Schedule of Benefits. The Schedule of Benefits describes covered dental services and procedures and applicable copayments. The Dental Care Plan covers only services and procedures on the Schedule of Benefits, when provided by a participating dental provider identified in the Concordia Plus DHMO Directory of Participating Dental Providers.

The Evidence of Coverage and Disclosure Form and Schedule of Benefits, provided by United Concordia, are part of this Summary Plan Description.

If you have any questions about your dental benefits, please call the United Concordia Customer Service Department toll free at (800) 937-6432, or visit the United Concordia Web site: https://www.unitedconcordia.com/dental-insurance/member/.

VIII. LIFE INSURANCE

Employee Life Insurance is provided directly by the Health Benefit Plan in the amount of $10,000. When proof of your death is received, the amount of Life Insurance is paid to your named beneficiary.

Dependent Life Insurance is also provided directly by the Health Benefit Plan in the following amounts:

Legal Spouse or Domestic Partner	$10,000
Children	$5,000

Only eligible Employees and their Dependents, as defined in Article II, are covered for Life Insurance. Life Insurance coverage ends when eligibility ends under Article II, except that eligibility for Life Insurance does not continue during eligibility under Article II, section 8. Life Insurance may not be continued under Disability or COBRA.

When proof of a Dependent's death is received, the Dependent Life Insurance Benefit is paid to the Employee.

BENEFICIARY FOR EMPLOYEE LIFE INSURANCE
You may name or change any beneficiary at any time by filing a written notice in the Administrative Office. Any change will take effect after it is received, provided benefits have not been paid before it was received.

If you name more than one beneficiary but do not state amounts or order of payment, benefits will be equally divided.

If you name more than one beneficiary and one dies before you, his or her share will go equally to the surviving beneficiaries, or to the sole surviving beneficiary.

If you have not named a beneficiary at the time of your death, or if your named beneficiaries all predecease you, benefits will be paid to the members of the first surviving class as follows:

1. Your Spouse or Domestic Partner
2. Your Children and your covered children of enrolled Domestic Partner
3. Your Parents
4. Your Brothers and Sisters
5. Your Estate

If there are no beneficiaries, up to $1,000 of the benefits may be paid to anyone who pays expenses for your final illness or funeral. Any payment the Health Benefit Plan makes in good faith under these provisions will discharge the Health Benefit Plan's liability to the extent of the payment.

IX. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Accidental Death and Dismemberment Insurance is provided directly by the Health Benefit Plan in the amount of $10,000. This coverage does not apply to Dependents. Only eligible Employees, under Article II (without regard to section 8), are covered for Accidental Death and Dismemberment. Accidental Death and Dismemberment Benefits may not be continued under Disability or COBRA.

When proof of your death is received, the amount of Accidental Death and Dismemberment Insurance is paid to your named beneficiary. You may name or change any beneficiary at any time by filing a written notice in the Administrative Office. If you have not named a beneficiary at the time of your death, benefits will be paid as shown under Life Insurance (Article VIII).

When, within ninety days after and as a direct result of an accidental injury, you sustain one of the losses listed below, a dismemberment benefit will be paid to you. The accidental death benefit, if applicable, will be paid to your named beneficiary.

For the loss of the following a $10,000 benefit will be paid:

1. Life
2. Both hands or both feet
3. Sight of both eyes
4. One hand and one foot
5. One hand and sight of one eye
6. One foot and sight of one eye

For the loss of the following a $5,000 will be paid:

1. One hand or one foot
2. Sight of one eye

Only one benefit, in the greater of the amounts payable, will be paid as a result of all injuries or losses sustained in any one accident.

Loss means, with respect to hands and feet, the actual severance at or above the wrist or ankle joint, with respect to eyes, the entire and irrecoverable loss of sight.

EXCLUSIONS
This benefit does not cover the following:

1. Loss caused by war or any act of war, loss occurring during air travel, suicide or any attempt at suicide; and loss which occurs while the covered person is committing a felony.

2. Loss due to disease or bacterial infection (except pus-forming infection occurring with an accidental wound); loss due to diabetes or any sickness attributable to diabetes.

3. Loss due to injection, inhalation or ingestion of any substance for purposes other than those prescribed by a doctor.

X. EXTENDED COVERAGE FOR HEALTH AND DENTAL COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

In accordance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), each "qualified beneficiary" will be entitled to COBRA coverage, which is a temporary extension of health coverage under the Plan at group rates when such coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are shown in the chart below.

After a qualifying event occurs, and any required notice of that event is timely provided to the Administrative Office, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." Depending on the qualifying event, qualified beneficiaries can include the covered employee, the employee's covered spouse or Domestic Partner, and the employee's covered children. Qualified beneficiaries who elect COBRA coverage must pay for it.

COBRA coverage is the same health coverage that the Plan gives to covered employees and dependents who are not receiving COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as employees and dependents with active coverage under the Plan, including open enrollment and special enrollment rights. However, qualified beneficiaries will not be considered Plan "participants" (i.e., Employees or Dependents) during a period of COBRA coverage.

The chart below shows all of the qualifying events that can occur under this Plan. It also shows the qualified beneficiaries who are entitled to elect COBRA, as well as the maximum COBRA coverage period, for each type of qualifying event.

Qualifying Event	Qualified Beneficiary (if covered under plan)	Maximum COBRA Coverage Period
1. Reduction in covered employee's hours of employment	Employee, spouse/Domestic Partner and children	18 months from the date Plan coverage is lost due to the qualifying event
2. Termination of covered employee's employment (for reasons other than the employee's gross misconduct)	Employee, spouse/Domestic Partner and children	18 months from the date Plan coverage is lost due to the qualifying event
3. Death of covered employee	Spouse/Domestic Partner and children	36 months from the date Plan coverage is lost due to the qualifying event
4. Divorce or legal separation from covered employee or cessation of Domestic Partnership status under the Plan	Spouse/Domestic Partner and dependent children	36 months from the date Plan coverage is lost due to the qualifying event
5. Loss of child status under Plan (such as if the child turns 26)	Affected child	36 months from the date Plan coverage is lost due to the qualifying event

How Extended Active Coverage Affects COBRA Coverage
The 18-, 29-, or 36-month maximum COBRA coverage period will not be reduced by months of free or subsidized coverage provided by the Plan in the event of disability (See Article II).

Alternative To COBRA: Marketplace Coverage

In addition to COBRA coverage from the Plan, you and your family members may have health insurance options under the Affordable Care Act available through the Health Insurance Marketplace (also known as the Exchange). Buying health insurance coverage from the Marketplace is an alternative to COBRA coverage.

- Health insurance coverage purchased through the Marketplace may cost less than COBRA coverage, and there may be more coverage options available to you, including options with lower out-of-pocket costs. Marketplace coverage may provide lower or higher benefits than COBRA coverage. Be sure to compare benefits and premiums.

- In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA coverage won't limit your eligibility for a tax credit through the Marketplace, though you will not be eligible for coverage or tax credits in the Marketplace while you are enrolled in COBRA (see next bullet point for information on enrolling in Marketplace coverage after electing COBRA coverage).

- Generally, you must enroll in Marketplace coverage within 60 days of your loss of Plan coverage or during a Marketplace annual open enrollment period. If you enroll in COBRA, you may not enroll in Marketplace coverage until the next Marketplace annual open enrollment period, or upon the exhaustion of your COBRA coverage (i.e., after the end of your maximum COBRA coverage period of 18, 29 or 36 months), or if you have a qualifying event such as marriage or birth of a child through something called a "special enrollment period."

- Preexisting condition exclusions are prohibited under the Affordable Care Act for COBRA and Marketplace coverage.

For more information about health insurance options available through a Health Insurance Marketplace in California, or to apply for coverage, go to www.coveredca.com.

If you live outside of California, more information about health insurance options is available at www.healthcare.gov or call 1-800-318-2596.

Notification Requirements
The Plan will offer COBRA coverage to each qualified beneficiary only after the Administrative Office has been timely notified that a qualifying event has occurred.

Your Obligation to Notify the Administrative Office: You or your Dependents are responsible for notifying the Administrative Office of a qualifying event that is divorce, legal separation, cessation of Domestic Partnership status, or loss of child status. Notice must be written and given within 60 days after the date Plan coverage is lost due to the qualifying event. Your written notice must contain the following information: (i) the name of the Plan; (ii) the employee's name; (iii) the name(s) of the employee's Dependent(s); (iv) the address(es) and telephone number(s) of the employee and his or her Dependent(s); and (v) the date and nature of the qualifying event. The Administrative Office may also require that supporting documentation be submitted, such as a divorce decree. If the required notice is not timely submitted to the Administrative Office, you and/or your Dependents will lose the right to elect COBRA coverage.

You or your Dependents are also responsible for notifying the Administrative Office in writing of a second qualifying event, disability determination, or end of disability (explained in more detail below under "Extensions of COBRA Coverage").

Finally, you should notify the Administrative Office of your retirement or a change in address for you or a Dependent, as well as changes in marital or Domestic Partnership status. You should keep copies, for your records, of any notices you send to the Administrative Office.

Employer's Obligation to Notify the Administrative Office: Your employer is responsible for informing the Administrative Office of an employee's death. Your employer is also required to submit monthly reports of hours worked to the Administrative Office, which will enable the Administrative Office to determine whether a qualifying event that is the termination of employment or reduction in hours of employment has occurred. However, to ensure that you are timely notified of your COBRA rights, you or your Dependent should also notify the Administrative Office promptly and in writing if any of these events occur in order to avoid confusion over the status of your health care coverage in the event there is a delay or oversight in the employer's transmittal of information to the Administrative Office.

Electing COBRA Coverage

Within 14 days after the Administrative Office receives timely notice of a qualifying event, it will provide a COBRA election notice and election form to affected qualified beneficiaries. This notice will contain detailed information concerning COBRA coverage and its cost.

Each qualified beneficiary will be offered a choice between a Core-Only plan of benefits (medical and prescription drug) and a Core-Plus plan of benefits (medical, prescription drug, and dental). All qualified beneficiaries in one family unit are not required to elect the same plan of benefits. However, the benefits shall be under the same medical plan (Indemnity Medical Plan or Kaiser) under which the qualified beneficiary was eligible on the day before the occurrence of the qualifying event. Each qualified beneficiary will be allowed to change medical plans on the same basis as employees and dependents with active Plan coverage (e.g., during open enrollment).

To elect COBRA coverage, you or your Dependent must complete the election form and submit it to the Administrative Office according to the directions on the form and within 60 days after the later of:

1. The date coverage under the Plan is lost because of the qualifying event, or
2. The date the Administrative Office mails the election notice.

An election is considered to be made on the date the completed and signed election form is mailed to the Administrative Office. If COBRA coverage is not elected within this 60-day election period, the right to elect COBRA coverage will be lost.

If a qualified beneficiary rejects COBRA coverage before the date the election form is due, (s)he may change his/her mind as long as (s)he sends the completed and signed election form to the Administrative Office before the due date. However, if a qualified beneficiary changes his/her mind after first rejecting COBRA coverage, his/her COBRA coverage will begin on the date the completed and signed election form is sent to the Administrative Office.

Each qualified beneficiary has an independent (i.e., separate) right to elect COBRA coverage. For example, your spouse or Domestic Partner may elect COBRA, even if you do not. COBRA coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. You may elect COBRA coverage on behalf of your spouse/Domestic Partner, and parents may elect COBRA coverage on behalf of their children.

In considering whether to elect COBRA coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's or Domestic Partner's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

If the Administrative Office receives a notice relating to a qualifying event or disability determination regarding an employee, spouse/Domestic Partner, Dependent child, or other person, and it determines that such person is not entitled to COBRA coverage, the Administrative Office will provide to such person a written denial notice containing the reason for the denial.

Adding Dependents to COBRA Coverage
A child who is born to, or adopted or placed for adoption with, the employee during a period of COBRA coverage becomes a qualified beneficiary entitled to COBRA in his or her own right. Such a child would, for example, be eligible for extended COBRA coverage for up to 36 months if the covered employee dies during the initial 18-month COBRA coverage period.

In contrast, a new spouse/Domestic Partner, or a child who is not a newborn or new adoptee of the employee can be enrolled under COBRA, but is not a qualified beneficiary with independent COBRA rights. If the covered employee's COBRA coverage ends for any reason, the new spouse/Domestic Partner or Dependent child's COBRA coverage will end too.

In order to add a Dependent to COBRA coverage, the COBRA enrollee must notify the Administrative Office in writing within 30 days of birth, adoption, marriage, registration of Domestic Partnership, or other event leading to the acquisition of the new Dependent. You may be required to submit written proof of dependency to the Administrative Office.

Payment Requirements
Each qualified beneficiary must pay the full cost of COBRA coverage by paying a monthly premium to the Administrative Office. The cost of COBRA coverage is based upon federal law. COBRA rates will be 102% (or 150% in the case of an extension of COBRA coverage due to a disability) of the cost of group coverage for active employees.

The first COBRA payment must be postmarked within 45 days of the date the COBRA election was sent (this is the date the completed and signed COBRA election form is post-marked, if mailed). The first COBRA payment must include any months retroactive to the date Plan coverage terminated. You are responsible for making sure that the amount of the first payment is correct. You may contact Administrative Office to confirm the correct amount of the first payment. COBRA coverage will not be effective until the first payment is received.

Subsequent payments must be made on a monthly basis and are due on the first day of each month for which COBRA coverage is desired (e.g., payment is due on January 1st for COBRA coverage in January). If a monthly payment is made on or before the first day of the month to which it applies, COBRA coverage will continue for that month without any break. The Administrative Office will not send monthly bills or warning notices of payments due for these coverage periods. It is the responsibility of you or your Dependents to send the required payments when due.

There is a 31-day grace period to make each monthly COBRA payment. That means that each monthly COBRA payment must be postmarked within 31 days after the due date. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period.

All payments for COBRA coverage must be in the form of a personal check, cashier's check, or money order payable to the Santa Monica UNITE H.E.R.E. Benefit Fund and remitted to the Administrative Office.

No benefit claim will be honored unless the required payment for the period in which the claim was incurred is timely sent. Please note that if any health care provider, such as a doctor or pharmacy, inquires about your eligibility, the Plan is required by law to make a complete disclosure of whether or not the COBRA election period has expired, or whether COBRA has been elected but not yet paid.

If payment for COBRA coverage is not timely made in full, you will lose all rights to COBRA coverage under the Plan as of the end of the last month for which a COBRA payment was properly made.

Extensions of COBRA Coverage
There are three ways in which a maximum COBRA coverage period of 18 months can be extended.

Entitlement to Medicare: When the qualifying event is the termination of employment or reduction in hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, the maximum COBRA coverage period for qualified beneficiaries other than the employee is 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/Domestic Partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability: If, during an 18-month maximum COBRA coverage period, a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled, the qualified beneficiary (and his/her family members who have also elected COBRA) may be entitled to receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. Each qualified beneficiary who has elected COBRA coverage will be entitled to the 11-month disability extension if one of them qualifies. The disability has to have started at some time before the 60th day of COBRA coverage and must last at least until the end of the initial 18-month period of COBRA coverage. COBRA premiums during this disability extension period will increase to 150% of the cost of group coverage. In order to qualify for this extension, you or your Dependent must notify the Administrative Office in writing of the SSA's determination within 60 days after the date of the SSA determination (or if the qualified beneficiary is already disabled, within 60 days after the date coverage is lost due to the qualifying event), but before the end of the initial 18-month maximum COBRA coverage period. This written notice must include the following information: (i) the name of the Plan; (ii) the employee's name; (iii) the name(s) of the employee's Dependent(s); (iv) the address(es) and telephone number(s) of the employee and his or her Dependent(s); (v) the date of the SSA's disability determination; and (vi) a copy of the SSA determination letter. This disability extension will terminate if the SSA makes a final determination that the qualified beneficiary is no longer disabled before the end of the 11-month disability extension period. If this is the case, you or your Dependent must notify the Administrative Office in writing of such within 30 days after the date of the final SSA determination. The notice must contain the information listed in the above paragraph.

Second Qualifying Event: If, during an 18-month maximum COBRA coverage period, a second qualifying event occurs that is the former employee's death, divorce or legal separation, cessation of Domestic Partnership status, or loss of child status under the Plan, COBRA coverage for the affected spouse, Domestic Partner, and/or child may be extended to 36 months. These events can be a second qualifying event only if they would have caused the spouse/Domestic Partner or child to lose Plan coverage if the first qualifying event had not occurred. In order to qualify for this extension, you or your Dependent must notify the Administrative Office in writing of the second qualifying event within 60 days after the date of such event. This written notice must include the following information: (i) the name of the Plan; (ii) the employee's name; (iii) the name(s) of the employee's Dependent(s); (iv) the address(es) and telephone number(s) of the employee and his or her Dependent(s); and (v) the date and nature of the qualifying event. The Administrative Office may also require that supporting documentation be submitted, such as a divorce decree.

Early Termination of COBRA Coverage
COBRA coverage will end before the 18-, 29-, or 36-month maximum COBRA coverage period expires if any of the following events occur:

1. The required payment for COBRA coverage is not timely remitted to the Administrative Office (i.e., the full amount is not postmarked by the 31st day after the payment due date).

2. A qualified beneficiary becomes covered, after electing COBRA, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a pre-existing condition

exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

3. A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA coverage (COBRA coverage for any family member who is not covered by Medicare will not be affected).

4. The employee's employer ceases to contribute to the Fund, but provides other group health plan coverage for its employees.

5. The Social Security Administration (SSA) determines that a qualified beneficiary is no longer disabled. You must inform the Administrative Office within 30 days of such SSA determination, in which case the extended COBRA coverage period will terminate for all qualified beneficiaries whose extended coverage derived from the disability at the end of the month in which the SSA makes its determination.

6. This Plan terminates.

Also, COBRA coverage may be terminated for any reason the Plan would terminate coverage of an employee or dependent not receiving COBRA coverage (such as fraud).

Once COBRA coverage ends for any reason, it cannot be reinstated. Furthermore, any claims incurred after the COBRA coverage termination date will not be paid by the Plan.

If COBRA coverage is terminated before the expiration of the 18-, 29-, or 36-month maximum COBRA coverage period, the Administrative Office will send the affected qualified beneficiary a written termination notice as soon as reasonably practicable after it determines that the COBRA coverage will end. Such notice will contain the following: (i) the reason for early termination; (ii) the termination date; and (iii) any rights the qualified beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage, such as a conversion right.

EXTENSION OF COVERAGE UNDER THE CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT (CAL-COBRA)
KAISER ENROLLEES ONLY

If you are a COBRA enrollee covered under the Kaiser HMO Plan, this California law supplements federal COBRA by requiring the Kaiser Foundation Health Plan to offer an extension of group health plan coverage for up to 18 months under certain circumstances. This means that you may be able to receive up to 36 months of continued coverage from the date federal COBRA coverage first started.

This Cal-COBRA extension is only available to COBRA enrollees covered under Kaiser who:

- Began receiving federal COBRA coverage on or after January 1, 2003;
- Have a maximum federal COBRA coverage period of less than 36 months; and
- Have exhausted such federal COBRA coverage.

Cal-COBRA coverage only includes medical and hospital benefits. Also, Cal-COBRA coverage is subject to payment of premiums directly to Kaiser Foundation Health Plan and can cost up to 110% (150% for the disability extension) of the applicable group rate. You must contact Kaiser Foundation Health Plan for the premium required to continue your coverage under Cal-COBRA. All other terms and conditions that apply to federal COBRA coverage apply to Cal-COBRA coverage. Cal-COBRA coverage will not be available if your federal COBRA coverage terminates before the end of the 18- or 29-month period or if you and/or your spouse or former spouse were eligible but did not elect federal COBRA. You must elect Cal-COBRA coverage by notifying Kaiser in writing within 30 calendar days prior to the date your federal COBRA coverage is scheduled to end.

Please refer to the Kaiser Evidence of Coverage booklet for more information regarding Cal-COBRA,

including detailed information on what you must do to enroll for this special extension. If you have any questions about Cal-COBRA coverage, please contact Kaiser directly.

MEDICAL CONVERSION

If you and/or your Dependents are covered under the Kaiser HMO plan, you and/or your covered Dependents may be entitled to convert from the Health Benefit Plan's group plan to an individual policy as set forth in the medical conversion provision of the group policy when continued health insurance ends. If you want this conversion coverage, contact the Kaiser Foundation Health Plan immediately on termination of your continued coverage, as you only have a limited time to apply for it. Medical conversion is not available under the EHS EPO Plan.

XI. OTHER RIGHTS AND OBLIGATIONS UNDER THE PLAN

FAMILY MEDICAL LEAVE ACT (FMLA)

The federal Family and Medical Leave Act (FMLA) generally requires covered employers to permit eligible employees to take up to 12 weeks of unpaid, job-protected leave each year (26 weeks in certain circumstances). The leave must be taken for one of several reasons that are specified by law. Details concerning FMLA leave are available from your employer. Requests for FMLA leave must be directed to your employer; the Administrative Office cannot determine whether or not you qualify.

To the extent required by the FMLA, your employer must continue to pay for your health coverage under the Plan during any approved FMLA leave. If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your share of the premiums), you may resume your coverage upon return from leave on the same terms that applied before the leave was taken.

You will not be entitled to COBRA coverage simply by taking an FMLA leave. However, if you do not return to work after taking an FMLA leave, you may have COBRA rights, even if you decline to continue your health coverage under the Plan or fail to pay the premium for such coverage during the leave.

If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you will be permitted to continue your health coverage under COBRA. If the dispute is resolved in your favor, the Administrative Office will obtain the FMLA-required contributions from your employer and will refund any corresponding COBRA premium payments to you. If your employer continues your coverage under the Plan during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Plan for your health coverage during the leave.

MILITARY SERVICE (USERRA)

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act (USERRA), covered employees can pay for a temporary extension of health coverage under the Plan at group rates for themselves and their covered family members if they would otherwise lose such coverage due to the employee's service in the uniformed services.

This extension of coverage ("USERRA coverage") can last up to 24 months, beginning on the date of the employee's absence from employment to perform uniform services.

A person electing USERRA coverage may be required to pay for all or part of the cost of such coverage. If you perform service in the uniformed services for fewer than 31 days, you will pay the same amount for the coverage that you normally pay. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage.

USERRA coverage may terminate before the expiration of the 24-month coverage period if:

1. The employee fails to pay required premiums on time.
2. The employee fails to report back to work or apply for reemployment in a timely manner following the completion of uniformed service.
3. The employee loses USERRA rights as a result of certain types of undesirable conduct, including court-martial and dishonorable discharge.
4. The employer no longer provides group health coverage to any of its employees.

Covered employees have the right to have their health coverage under the Plan reinstated if: (1) such coverage was terminated as a result of uniformed service; (2) the employees are reemployed following completion of such service; and (3) other requirements are met.

For more information about USERRA coverage, including how to elect such coverage and payment amounts and deadlines, contact the Administrative Office.

COVERAGE FOR WORKING EMPLOYEES AND DEPENDENTS ELIGIBLE FOR MEDICARE (Dental and Prescription Drug Coverage Not Affected)

If you are in one of the following categories, federal law requires that the Plan offer you the choice of this Plan or Medicare as your Primary carrier.

1. Active employees who are eligible for Medicare and are age 65 or older.

2. The spouse or Domestic Partner of any employee, where the spouse is age 65 or older.

If you choose this Plan as primary, Medicare will provide additional or secondary coverage. If you select Medicare as primary, the Hospital, Medical and Surgical benefits described in this Summary Plan Description will **NOT** be available to you at all.

IF YOU WANT MEDICARE AS YOUR PRIMARY COVERAGE, YOU MUST SUBMIT A WRITTEN STATEMENT TO THE PLAN REJECTING YOUR COVERAGE UNDER THE PLAN.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Federal law requires the Plan, under certain circumstances, to honor the terms of a Qualified Medical Child Support Order (QMCSO) providing continued health care coverage for your children. A QMCSO is an order, decree, judgment, or administrative notice (including a settlement agreement) issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, which meets the requirements of Section 609 of ERISA.

If the Plan receives a QMCSO, child(ren) identified will be included for coverage as your eligible dependent. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you do not.

Any payment for benefits made by the Plan under the QMCSO as reimbursement for expenses paid by either the child or the child's custodial parent or legal guardian must be paid to the alternate recipient or that child's custodial parent or legal guardian. Any such payments made to the custodial parent or the legal guardian or to an official of a State or its political subdivision (whose name and address are used for the address of an alternate recipient) will be treated as payment of benefits to the alternate recipient.

If you have any questions about any of these requirements, contact the Administrative Office.

XII. APPEALS TO THE BOARD OF TRUSTEES

Appeals for Medical, Vision, Dental, and Prescription Drug Claims

If you believe you have been denied a benefit improperly, or received a benefit less than the benefit to which you are entitled, under the following benefits, you must follow the procedures associated with such benefit:

•EHS EPO Plan
•Kaiser HMO Plan
•Express Scripts Prescription Drug Benefit
•United Concordia Dental Plan.

In the case of the EHS EPO Plan only, you may appeal certain decisions of EHS to the Board of Trustees, using the procedures described below. However, the Board of Trustees cannot consider any appeal based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is medically necessary or appropriate.

Appeals Related to Eligibility to Enroll for Benefits
Appeals for Life Insurance and Accidental Death & Dismemberment

If you believe that you or your Dependents have improperly been denied enrollment in any benefit under the Plan, you must appeal to the Board of Trustees.

If you believe you have been denied a benefit improperly, or received a benefit less than the benefit to which you are entitled, for Life Insurance or Accidental Death and Dismemberment, you have the right to appeal to the Board of Trustees.

Deadline to Request Appeal. You have at least 180 days following receipt of a notification of a denial of enrollment or benefits within which to appeal to the Board of Trustees.

When Appeals Will Be Considered. Appeals will be considered at the meeting of the Board of Trustees immediately following submission of the appeal, unless the appeal is submitted within 30 days preceding the date of such meeting. In such case, the appeal will be considered at the second meeting following the plan's receipt of the appeal. If special circumstances require a further extension of time for processing, you will receive a written notice of the extension, describing the special circumstances and the date as of which the appeal will be considered, prior to the commencement of the extension.

Appeal Rights and Procedures. You may authorize a representative to act on your behalf in making an appeal to the Board of Trustees. You may submit written comments, documents, records, and other information relating to your claim to the Board of Trustees. Upon request and free of charge, you will be provided copies of all documents, records, and other information relevant to your claim for benefits, including all documents submitted, considered, or generated in the course of making the benefit determination, as well as any statement of policy or guidance with respect to the plan concerning the denied benefit.

When You Will Receive Notice of the Decision on Appeal. You will receive notice of the decision of the Board of Trustees on an appeal as soon as possible, but not later than 5 days after the Board of Trustees meeting at which the appeal was decided.

Trustee Authority: The Board of Trustees has the absolute right, in its sole discretion, to make factual determinations relating to benefit claims, and to interpret the terms of this Plan.

XIII. INFORMATION ABOUT THE ADMINISTRATION OF THE PLAN

1. Name of the Plan

The name of the Plan is the Santa Monica **UNITE HERE Health Benefit Plan**.

2. Name and Address of the Board of Trustees

Board of Trustees of the Santa Monica **UNITE HERE Health Benefit Plan** c/o Benefit Programs Administration, 13191 Crossroads Pkwy North, Suite 205, City of Industry, California 91746-3434. (866) 345-5189 or (562) 463-5075. Fund Web site: www.santamonicauniteherefunds.org.

A complete list of the employers and employee organizations sponsoring the plan, or information as to whether a particular employer or employee organization is a sponsor of the plan (and, if so, the sponsor's address) may be obtained upon written request to the Plan Administrator.

3. Employer Identification Number

The taxpayer identification number assigned to the Health Benefit Plan by the Internal Revenue Service is EIN 95-6035138. The plan number is 501.

4. Type of Plan

The Plan is a welfare plan that provides medical, dental, life insurance, accidental death and dismemberment, vision care and prescription drug benefits.

5. Type of Administration

The Board of Trustees has contracted with insurers and a third party administrator to conduct the daily operations of the Plan.

Plan benefits are provided through contract or insurance with the following service providers:

For Medical, MAP, and Vision Benefits
Employee Health Systems Medical Group (EHS)
1200 Corporate Center Dr. Suite 200
Monterey Park, California 91754
(310) 641-1997 or (800) 231-1407

For Medical and Vision Benefits
Kaiser Foundation Health Plan, Inc.
3100 Thorton Ave
Burbank, CA 91504
(818) 557 - 3968

For Dental Benefits
United Concordia Companies
21700 Oxnard Street, Suite 500
Woodland Hills, California 91367
(818) 710-9400

For Retail Prescription Drug Benefits
Express Scripts Claims Dept
STL – 1409
P.O. Box 63166
St. Louis, MO 63166

For Mail Order Prescription Drug Benefits
Express Scripts, Inc.

P.O. Box 66568
St. Louis, MO 63166
(800) 606 - 5667

6. Name, Address and Telephone Number of the Plan Administrator

Board of Trustees of the **UNITE HERE Health Benefit Plan**
c/o Benefit Programs Administration,
13191 Crossroads Pkwy North, Suite 205,
City of Industry, California 91746-3434.
(866) 345-5189 or (562) 463-5075

7. Name and Address of Agent for Service of Process

The Board of Trustees has appointed Richard D. Sommers, Esq., Schwartz, Steinsapir, Dohrmann & Sommers, 6300 Wilshire Blvd., Suite 2000, Los Angeles, California 90048-5204, as its agent for service of legal papers.

8. Names and Addresses for Trustees

Employer Trustees

Ms. Teri Serrano
8639 Lincoln Ave
Los Angeles, CA 90045

Mr. Jerry Katzman (Alternate Trustee)
525 N. Sepulveda Blvd.
El Segundo, CA 90245

Union Trustees

Mr. Tom Walsh
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Mr. Austin Lynch
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Ms. Kristin Reeg (Alternate Trustee)
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Mr. Jef Eatchel (Alternate Trustee)
654 Euclid Lane
El Cajon, CA 92019

9. Collective Bargaining Agreements

The Plan is maintained pursuant to one or more collective bargaining agreements. Upon written request, the Administrative Office will advise an Employee or Dependent if a particular employer has entered into a collective bargaining agreement requiring contributions to the Plan. Copies of any collective bargaining agreement may be obtained by Employees and their Dependents upon written request to the Plan Administrator, and is available for examination by Employees and their

Dependent's at the Plan Administrator's office.

10. Source of Contributions

The Plan is funded by Employer contributions, as specified in Collective Bargaining Agreements. Employees and Dependents may pay premiums as required for Continuation Coverage.

11. Funding Medium

All Plan assets are held in the Santa Monica UNITE HERE Health Benefit Trust Fund. The Kaiser HMO Plan and the United Concordia Dental Benefit are provided through insurance contracts.

12. Plan Year

The records of the Plan are maintained on a calendar year basis. The end of the Plan Year is December 31.

13. Statement of Participants' and Beneficiaries' ERISA Rights

Participants in the Plan (Employees and Dependents enrolled for coverage) 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:

Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Administrative Office during usual business hours, all documents governing the Plan, including insurance contracts, provider service agreements, the Collective Bargaining Agreement under which a participant is covered and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor, and are available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain 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, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c. 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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for the 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 your employer, your union, or any other person may fire you or discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied 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 in 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 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 plans 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, 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 have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

If you have any questions about 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 publications hotline of the Employee Benefits Security Administration.

GRANDFATHERED HEALTH PLAN NOTICE

The Fund believes that the medical plans offered (the EHS EPO plan and the Kaiser HMO plan) are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Effective January 1, 2015, the Kaiser HMO Plan is no longer a Grandfathered Plan.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed in writing or by phone to the Plan Administrator at Board of Trustees of the Santa Monica **UNITE HERE Health Benefit Plan** c/o Benefit Programs Administration, 13191 Crossroads Pkwy North, Suite 205, City of Industry, California 91746-3434. (866) 345-5189 or (562) 463-5075. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call the Plan Administrator.