Santa Monica UNITE HERE Health Benefit Trust Fund

SUMMARY PLAN DESCRIPTION

&

PLAN DOCUMENT

Effective January 1, 2020

Administrative Office
Benefit Programs Administration
1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017

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 of Trust Providing for the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Trust Agreement"). Appointed by the Union and certain Employers, the Board of Trustees of the Fund design, administer, and maintain the Plan.

The Plan offers eligible Employees and their Dependents medical, prescription drug, dental, and vision benefits. Life insurance, accidental death and dismemberment benefits, and Member Assistance Program ("MAP") benefits are also provided.

- Medical, dental, vision, and MAP benefits are provided through contracts between the Fund and various Health Maintenance Organizations ("HMOs") and insurance companies. These benefits are described in separate documents issued by the HMOs and insurance companies. For your convenience, brief summaries of these benefits are included in this booklet; however, detailed information can be found in the official insurance company documents that describe the benefits.

- The Prescription Drug Program is provided by Express Scripts under a contract with the Fund. All outpatient prescriptions, whether you are in the HealthNet HMO plan or the Kaiser HMO plan, must be obtained from an Express Scripts network pharmacy or, if applicable, through Express Script's mail order program.

- Beginning January 1, 2020, a separate vision benefit (materials only) will be provided through an insurance contract with Vision Service Plan (VSP). Eye exams will be covered by the Fund's HMO medical plans.

- Life Insurance and Accidental Death & Dismemberment benefits are provided directly by the Fund and are described in this booklet.

This booklet together with the Trust Agreement and other governing/plan documents, constitutes the Fund's Plan Document. With respect to medical, dental, vision, and MAP benefits, this booklet is not intended to give Employees and their Dependents any substantive rights to benefits that are not provided by the insurance contracts, Evidences of Coverage and other governing documents issued by the respective insurance company or HMO.

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

Important information, forms, and documents
are *available on the internet at:*
www.santamonicauniteherefunds.org

FOR HELP AND INFORMATION

When you need information, please review this Summary Plan Description. If you need further help, call the Fund's service providers listed under Whom to Contact in the following Reference Chart:

REFERENCE CHART	
WHOM TO CONTACT	**INFORMATION NEEDED**
Administrative Office of the Fund (866) 345-5189 (562) 463-5075 Address: 1200 Wilshire Boulevard, 5th Floor Los Angeles, California 90017	Call the Administrative Office for: • Eligibility status and questions; • Medical and dental enrollment; • Open enrollment; • ID Cards; • COBRA administration; • Beneficiary designation for Life Insurance; • General help.
HealthNet HMO Plan **Call:** Health Net Customer Contact Center (800) 522-0088	Call HealthNet for: • Find a primary care doctor; • Change your primary care doctor; • Help with preauthorization or referrals; • Claims • Appeals/Grievances; • To get a copy of your Evidence of Coverage ("EOC").
Kaiser Permanente HMO Plan (833) 574-2273 www.kp.org	Call Kaiser for: • Find a personal care physician; • Change your personal care physician; • Make an appointment; • Leave a message for your doctor; • Customer service; • Appeals; • To get a copy of your Evidence of Coverage ("EOC").
Prescription Drugs: **Call:** Express Scripts (800) 606-5667	Call Express Scripts for: • Questions about prescription benefits; • Assistance with a claim; • Requests for preauthorization; • Customer service for prescription drugs; • Help with mail order pharmacy.

REFERENCE CHART	
WHOM TO CONTACT	**INFORMATION NEEDED**
United Concordia Dental Care Plan **Call:** United Concordia (866) 357-3304	Call United Concordia for: • Information about dental insurance benefits under the United Concordia plan; • Help finding a United Concordia Provider;
Delta Dental PPO Dental Plan **Call:** Delta Dental (888) 335-8227	Call Delta Dental for: • Information about dental insurance benefits under the Delta Dental PPO Dental Plan; • Help finding a Delta Dental dentist
Vision Service Plan Benefit **Call:** VSP, Inc. 800-877-7195	Call VSP for: • Information about your vision benefits (materials only); • Help finding a VSP network provider.
Member Assistance Program (MAP) **Call:** Beacon Health Options 1-888-479-6606	Call Beacon Health Options for: • Help with personal problems, family and relationship issues, depression and anxiety • Legal and financial planning assistance • Concerns about Drug or alcohol use
Life Insurance **Call**: The Administrative Office (866) 345-5189; or (562) 463-5075	Call the Administrative Office to: • Change your beneficiary designation; • File a claim for benefits • Get information
Accidental Death & Dismemberment **Call:** The Administrative Office (866) 345-5189; or (562) 463-5075	Call the Administrative Office to: • Make a claim for benefits; • Make or change your beneficiary designation; • Get information about benefits
Appeals **Call:** The Administrative Office (866) 345-5189; or (562) 463-5075	Call the Administrative Office to: • Make a claim for benefits; • For questions about filing an appeal;

IMPORTANT NOTICE TO
EMPLOYEES AND DEPENDENTS

From time to time, the Administrative Office may mail you updated materials (such as a "Summary of Material Modifications") in order to inform you of changes to Plan benefits. It is important that you keep all literature received with this Summary Plan Description ("SPD") and note the affected sections.

The Trustees have discretionary authority to determine eligibility for benefits; to administer, apply, and construe the terms of the Plan and the SPD; to interpret any other Plan documents; and to decide all matters arising in connection with the operation or administration of the Fund. For benefits provided under insurance contracts (e.g., the HMO medical benefits, dental insurance, vision benefits, and MAP benefits), the insurer has authority to make benefits decisions.

Any interpretation of the Plan, and any determination of benefits under the Plan, made by the Trustees shall be final and binding as to all persons, including Employees, Dependents, Employers, and the Union.

In accordance with the terms of the Trust Agreement, the Board of Trustees reserves the right to amend or terminate the Plan at any time. Plan amendments may result in reductions in benefits or changes in eligibility rules. In addition, the Plan may be terminated upon the nonrenewal of all Collective Bargaining Agreements between UNITE HERE Union Local No. 11 and Participating Employers that require 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/Plan Document.

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I. GENERAL DEFINITIONS

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

1. **Administrative Office.** The administrative office of the Santa Monica UNITE HERE Health Benefit Trust Fund.

2. **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.

3. **Dependent.** A person who is eligible for benefits under the Plan as:

   A. Your legal spouse or Domestic Partner, as defined under the Plan; or

   B. Your child or your Domestic Partner's child who is less than 26 years of age, including a stepchild, a child who has been legally adopted or lawfully placed with you for adoption, or a child for whom you or your Domestic Partner have been appointed legal guardian.

4. **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 his/her 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 (i) are at least 18 years of age, (ii) hold themselves out as having a committed relationship, (iii) have lived together for at least 6 months, currently live together, and plan to continue living together indefinitely, (iv) have had no other spouse or Domestic Partner within the past 6 months, (v) are not related to each other to a degree that would prevent them from marrying, and (vi) have registered their union officially if the jurisdiction in which they live provides for such registration.

   To enroll a Domestic Partner for benefits, please contact the Administrative Office for an Application, a Declaration of Domestic Partnership Form, and additional information on enrollment requirements.

5. **Employee.** A person who works in a position that is covered by a Collective Bargaining Agreement or a Participation Agreement and for whom contributions are required to be made to the Fund."

6. **Employer or Participating Employer.** Any employer that has entered into a Collective Bargaining Agreement or a Participation Agreement that requires contributions to the Fund.

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

8. **Hours Worked or Hours.** Each hour worked by or paid to an Employee for which contributions are required under a Collective Bargaining Agreement or Participation Agreement and actually received by the Fund.

9. **Initial Eligibility Date.** The date that an Employee and his or her Dependent(s) first become eligible for benefits under the Plan.

10. **Participant.** A person eligible for benefits under the Plan, whether as an Employee or as the Dependent of an Employee. In addition, with respect to medical benefits (including prescription drug, vision, and MAP benefits), the eligible Employee or Dependent must be enrolled in one of the Fund's HMO medical plans (Health Net or Kaiser HMO). For dental insurance, the eligible Employee or Dependent must be enrolled in one of the Fund's dental plans (the Dental Care Plan by United Concordia or the Delta Dental PPO Plan).

11. **Participation Agreement.** An agreement between the Fund and an Employer or the Union, other than a Collective Bargaining Agreement, that requires an Employer or the Union to make contributions to the Fund and be bound by the terms of the Trust Agreement.

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

13. **Spouse.** The individual who is legally married to the Employee, as recognized under the laws of the state or jurisdiction in which the marriage was entered into.

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

15. **Trustees.** The Board of Trustees of the Santa Monica UNITE HERE Health Benefit Trust Fund.

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

17. **You.** Unless otherwise specified, the words "you," "your," and "yours" refer to an Employee.

II. ELIGIBILITY RULES

1. HOW YOU BECOME ELIGIBLE

You and your Dependents will become eligible for Plan benefits on your "Initial Eligibility Date."

Your Initial Eligibility Date is the first day of the third month following a period of 3 consecutive months, during which you worked at least 60 Hours in each of the 3 consecutive months for an Employer in a position covered by a Collective Bargaining Agreement **and** the Employer made the required contributions to the Fund.

For example, if you started working in January and worked at least 60 Hours per month in January, February, and March, you and your Dependents would become eligible for benefits on June 1, which is the first day of the third month after March. In this example, June 1 would be your Initial Eligibility Date.

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.

2. INITIAL ENROLLMENT

To get coverage when you're first eligible, you should return your completed enrollment materials to the Administrative Office as soon as possible after you receive them.

You will receive enrollment materials from the Administrative Office after you have been reported to the Fund as an Employee.

Coverage for you and your Dependent(s) will not be effective until you enroll. Enrollment in Life Insurance and Accidental Death & Dismemberment benefits, however, is automatic.

In order to enroll yourself and your Dependents in the Plan, you must return your enrollment materials to the Administrative Office within 90 days after your Initial Eligibility Date.

Note: For full benefits, you must complete two enrollment forms. Specifically, you must complete an enrollment form for the HMO medical plan (Health Net or Kaiser) in which you are enrolling and for the dental plan (United Concordia or Delta Dental) in which you are enrolling. If you enroll for medical coverage, you will automatically be covered under the Prescription Drug Program administered by Express Scripts, MAP benefits through Beacon Health Options, and vision benefits through VSP.

- If you return your enrollment materials before your Initial Eligibility Date, your coverage will begin on your Initial Eligibility Date. *For example, if you return your enrollment*

materials before your Initial Eligibility Date of June 1, your coverage will begin on June 1.

- If you return your enrollment materials after your Initial Eligibility Date, your coverage will begin on the first day of the month following the month in which you enroll. *For example, if you return your enrollment materials on June 15, which is after your Initial Eligibility Date of June 1, your coverage will begin on July 1.*

- **If you do not return the enrollment materials within ninety (90) days after your Initial Eligibility Date, you will not be able to enroll until the Plan's next annual Open Enrollment period** (see Section 6 of this Article II), unless you have a Special Enrollment opportunity (see Section 7 of this Article II).

To Enroll Your Dependents: You must complete your medical and/or dental enrollment forms and submit them to the Administrative Office, along with any required supporting documentation (including a marriage certificate for a Spouse; a Declaration of Domestic Partnership form for a Domestic Partner; and birth certificates for Dependent children), within the timeframes described above. *Under no circumstances will the Fund offer Dependent coverage only. You, the Employee, must be enrolled in order for your Dependents to be enrolled*. Once enrolled, you and your Dependents cannot disenroll or drop your medical coverage. You can choose to "opt out" of or drop your dental insurance and/or vision benefits through VSP.

You must notify the Administrative Office promptly of any change in your family status (such as marriage, divorce, death, or new children) or of your or your Dependent's enrollment in Medicare. If a change in family status (such as a divorce) results in your Dependent's no longer qualifying as a Dependent (for example, if you divorce, your spouse is no longer eligible for coverage from the Fund) or more of your

YOU ARE NOT ALLOWED TO DISENROLL.

Once you enroll for coverage, you are not allowed to disenroll from (or drop) medical coverage. You will have medical coverage from the Fund as long you work enough Hours to earn Eligibility, and your enrolled Dependents will lose coverage only if they no longer satisfy the definition of Dependent (for example, if you get divorced, your former spouse would no longer qualify as your Dependent) or if you do not work enough Hours to maintain your eligibility. The only exception to this rule involves the situation where the Participant is eligible for Medicare and wants Medicare to be primary, as described on page 42.

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(s) make(s) contributions to the Fund as required by a Collective Bargaining Agreement or Participation 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, and Plan coverage for you and your Dependent(s), 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 or Participation 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

If your coverage ends, you and/or your Dependents may be able to temporarily continue your Plan coverage through COBRA self-payments (see Article XIII, Section 1) or by using disability credits (see Section 8 of this Article II). In addition to these options for continuing coverage under the Plan, you may be able to enroll in an individual conversion plan through your HMO, in

individual health coverage through a health insurance exchange (Covered California), or 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, your eligibility will be reinstated 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 reinstated 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 months mentioned above, you will not be able to reinstate your eligibility; instead, you must re-establish your eligibility as a new Employee with 60 or more Hours in each of three consecutive months (see "How You Become Eligible," at 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 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 at least 60 Hours 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 (January, February, March, April). Therefore, Franklin is required to re-establish eligibility under Section 1 of this Article II. Because Franklin has 60 Hours or more in three consecutive months (May, June, and July) after losing his eligibility, 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 3 of this Article II.

6. OPEN ENROLLMENT

Open Enrollment is conducted at least once a year, usually during November and December, with any enrollment changes becoming effective the following January 1. 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 him or herself in the Plan, along with any Dependents.

- An Employee enrolled in the Plan, who did not previously enroll one or more Dependents, may enroll any eligible Dependents in the Plan.

- An Employee (and his or her Dependents) enrolled in the Health Net Plan may switch to the Kaiser HMO Plan, if the Employee is eligible to enroll in the Kaiser HMO Plan (see Article III, Section 1.B. for more information on Kaiser's eligibility rules). Similarly, an Employee (and his or her Dependents) enrolled in the Kaiser HMO Plan may switch to the Health Net Plan.

- An Employee (and his or her Dependents) enrolled in the Dental Care Plan provided by United Concordia may switch to the Delta Dental PPO Plan, if the Employee is eligible to enroll in the Delta Dental PPO Plan (see Article III, Section 3.B. for more information on Dental Dental's eligibility rules). Similarly, an Employee (and his or her Dependents) enrolled in the Delta Dental PPO Plan may switch to the United Concordia Dental Care Plan.

Your changes must be in writing and submitted to the Administrative Office before the end of the Open Enrollment period.

In general, changes made during Open Enrollment will become effective on the following January 1st, provided that you continue to be eligible for benefits at that time. Any changes you make during Open Enrollment cannot be modified until the next Open Enrollment period, unless a Special Enrollment opportunity arises (see Section 7 of this Article II for more information on Special Enrollment).

7. SPECIAL ENROLLMENT

Special Enrollment allows you, under certain situations, to (1) enroll yourself and/or your Dependent(s) in the Plan outside of Open Enrollment, even if you did not enroll when you were initially eligible and (2) switch your medical and/or dental plan choice to another plan option that is available to you and your Dependents without having to wait until Open Enrollment.

Special Enrollment is available only in the following circumstances:

- **Upon the Loss of Other Coverage.** If you did not enroll yourself of any of your Dependents in the Plan because you or your Dependent(s) had other health insurance or group health plan coverage, including coverage under Medi-Cal (or another state Medicaid program) or a state children's health insurance program (CHIP), and you or your Dependent(s) lose eligibility for that other coverage (or, if your other coverage was employer-provided group health coverage, and the employer stops its contributions toward the cost of the coverage), you may be able to enroll yourself and/or your Dependent(s) in the Plan.

  Special Enrollment rights are triggered **when there is a loss of other coverage due to** your divorce or legal separation or the termination of your Domestic Partnership, the cessation of dependent child status (such as attaining the maximum age to be eligible as a dependent child under the other coverage), the death of your Spouse or Domestic Partner, the termination of employment or reduction in the number of hours of your Spouse's or Domestic Partner's employment, or the exhaustion of COBRA continuation

coverage available through another group health plan. Special Enrollment rights do *not* apply when there is a loss of other coverage due to the failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), or voluntarily dropping such other coverage.

In order to receive Special Enrollment rights for loss of other coverage, you must provide proof of the involuntary loss of other coverage. If you are the one losing other coverage, then you and all of your eligible Dependents will have Special Enrollment rights. If your Dependent is the one losing coverage, then you and that Dependent will have Special Enrollment rights.

- **Upon the Addition of a New Dependent.** If you acquire a new Dependent as a result of marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your newly-acquired Dependent(s), plus your eligible Spouse or Domestic Partner (if applicable), in the Plan.

- **Upon Obtaining Eligibility for State Premium Assistance.** If you or any of your Dependents become eligible for a premium assistance subsidy under Medi-Cal (or another state Medicaid program) or under a state children's health insurance program (CHIP) with respect to coverage under the Plan, you may be able to enroll yourself and/or your Dependent(s) in the Plan.

Deadline for Requesting Special Enrollment. You must contact the Administrative Office to request Special Enrollment within 90 days after one of the following dates, as applicable: (1) the date you and/or your Dependent loses other coverage; (2) the date you acquire a new Dependent through marriage, Domestic Partnership, birth, adoption, or placement for adoption; or (3) the date you or your Dependent(s) are determined to be eligible for premium assistance.

Plan Coverage Start Date. If Special Enrollment is requested within this 90-day period, Plan coverage for you and/or your Dependent(s) will begin on the first day of the month after you request special enrollment, *with one exception*: if you request Special Enrollment within thirty (30) days after the date of a marriage, birth, adoption, or placement for adoption, Plan coverage will begin retroactively as of the date of the birth, adoption, or placement for adoption.

If you do not timely request Special Enrollment, you must wait until the next annual Open Enrollment period to enroll yourself and/or your Dependent(s), unless a different Special Enrollment event occurs beforehand. In addition, you must wait until Open Enrollment to enroll any Dependents who do not have Special Enrollment rights.

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, as follows:

- For up to 4 months if the injury or sickness was incurred outside work
- For up to 6 months if the injury or sickness was incurred while working

Disability credit is provided as if you worked 60 Hours in a month and will continue your eligibility for the third month after the month for which the credit is given. However, eligibility for Life Insurance under Article XI and Accidental Death & Dismemberment benefits under Article XII does not continue during periods of extended eligibility due to disability under this Article II, Section 8.

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 (FMLA) for extended coverage during a period of FMLA leave from your Employer. FMLA leave is typically unpaid leave available for certain family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own serious illness. The Plan provides extended coverage during periods of FMLA leave certified by your Employer. If you go on an FMLA leave of absence, please contact the Administrative Office. You may contact your Employer or the Administrative Office for more information on FMLA.

COBRA continuation coverage is also available if you lose coverage due to a reduction in hours or for certain other qualifying events. However, you must pay for COBRA. For details regarding COBRA, see Article XIII, Section 1.

9. IF YOU SHOULD DIE

If you should die, coverage for your Dependent(s) will continue to the end of the period for which you had earned eligibility. They may then be eligible for COBRA continuation coverage by making the appropriate payments. For details regarding COBRA, see Article XIII, Section 1.

10. IF YOU SHOULD DIVORCE (OR TERMINATE YOUR DOMESTIC PARTNERSHIP)

If you divorce or end your domestic partnership, coverage for your Spouse/Domestic Partner and his or her child(ren) will end on the last day of the month in which the divorce (or dissolution of marriage) or termination of your domestic partnership occurs. Your Spouse and/or stepchildren may then be eligible for COBRA continuation coverage by making the appropriate payments, if your divorce is timely reported to the Fund. For details regarding COBRA, see Article XIII, Section 1.

You must timely notify the Fund of your divorce or termination of your domestic partnership. If you do not notify the Fund within 60 days of your divorce (dissolution of marriage) or end of your domestic partnership, your former Spouse/Domestic Partner and his/her child(ren) will not be eligible to elect COBRA coverage.

11. NON-BARGAINED EMPLOYEES

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

12. RESCISSION OF COVERAGE

A rescission is a cancellation or discontinuance of Plan coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

The Plan will not retroactively cancel or terminate coverage (a rescission), except in the circumstances permitted by law, such as when contributions and self-payments are not timely paid, or, upon 30 days' advance written notice, in cases when an individual performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Retroactive termination of an ex-Spouse's coverage due to the failure to timely notify the Fund Office of a divorce or dissolution of marriage is not a "rescission of coverage."

The following examples constitute a material misrepresentation for which the Fund may rescind (retroactively cancel) coverage: enrolling someone as a Dependent who does not qualify as a Dependent or knowingly submitting a false claim or appeal for benefits.

If the Fund rescinds your Plan coverage, the result will be that you and your Dependents were never covered under the Plan, and you and your Dependents must repay the Fund the full amount it paid for all benefits (including premiums paid to your HMO) provided as a result of misrepresentation or fraud.

III. OUTLINE OF PLAN BENEFITS

1. MEDICAL BENEFITS

Medical benefits are provided to all eligible and enrolled Employees and their Dependents. You and your Dependents must be enrolled in the same medical plan.

A. Health Net of California, Inc. Plan

After your eligibility is established, you will be able to enroll yourself and your Dependents in the Health Net of California Plan (sometimes called the "Health Net Plan") for medical benefits. The Health Net Plan is briefly described in Article IV of this SPD.

B. Kaiser HMO Plan

After you have been covered under the Health Net Plan for at least 6 consecutive months, you may be able to switch to the Kaiser HMO Plan **during the next annual Open Enrollment period.** Not all Employees can switch to Kaiser. **In order to enroll in the Kaiser HMO Plan, you must satisfy the following requirements:**

- You must work for an Employer that contributes at least the minimum amount per hour required for coverage under the Fund's Kaiser HMO Plan;
- You must have been covered under the Fund's Health Net Plan for a minimum of 6 consecutive months after initially becoming eligible for Fund coverage; and
- You must live or work within 30 miles of a Kaiser Permanente medical group or facility.

Under certain limited circumstances, the Board of Trustees may authorize exceptions to the general rule described above.

The Kaiser HMO Plan is briefly described in Article V of this SPD.

C. Making the Choice between Health Net and Kaiser

If you have a choice between the Health Net Plan and 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), unless you have a Special Enrollment opportunity (see Article II, Section 7). The two plans are different.

You should review the brief descriptions of these plans in Articles IV and V of this SPD before making your decision. You can also compare the "Summary of Benefits and Coverage" for each plan, which can be obtained from the Administrative Office.

2. PRESCRIPTION DRUG BENEFITS

The prescription drug program described in this SPD is provided by Express Scripts to all eligible Employees and Dependents. You have the same Express Scripts prescription drug program benefits whether you are enrolled in the Health Net Plan or 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 Prescription Drug Program provided by Express Scripts is described in Article VI of this SPD.

3. DENTAL INSURANCE

Dental insurance is provided to all eligible Employees and their Dependents, but you must enroll yourself and your Dependents in one of the Fund's dental plans or you will not have dental insurance.

A. United Concordia

You can enroll yourself and your Dependents in the Dental Care Plan provided by United Concordia. You can always choose this dental plan, regardless of whether you are enrolled in Health Net or Kaiser. United Concordia's Dental Care Plan is briefly described in Article VII of this SPD.

B. Delta Dental

In order to enroll in the Delta Dental PPO Plan, you must work for an Employer that contributes at least the minimum amount per hour required for coverage under the Delta Dental PPO Plan. The Delta Dental PPO Plan is briefly described in Article VIII of this SPD.

4. VISION BENEFITS

Eye exams are covered by the Health Net Plan and the Kaiser HMO Plan.

A materials allowance (for glasses or contacts) is available through the Vision Service Plan Benefit ("VSP Benefit").

For more information on vision benefits and your cost sharing, see Article IX of this SPD.

5. MEMBER ASSISTANCE PROGRAM (MAP) BENEFITS

Member Assistance Program (MAP) benefits are provided by Beacon Health Options. The MAP is available to all eligible Employees and their Dependents, regardless of whether you are enrolled in Health Net or Kaiser. The MAP is briefly described in Article X of this SPD.

6. LIFE INSURANCE BENEFITS

Once your eligibility is established, you will automatically be covered for Life Insurance benefits; even if you do not enroll for medical coverage. However, you must be eligible for benefits in accordance with Article II (i.e., based on Hours Worked) at the time of your death in order to qualify for Life Insurance benefits. Life Insurance benefits are provided directly by the Fund on a self-funded basis (i.e., not through an insurance company), regardless of whether you are enrolled in Health Net or Kaiser. These benefits are described in detail in Article XI of this SPD.

7. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Once your eligibility is established, you will automatically be covered for Accidental Death & Dismemberment benefits, even if you do not enroll for medical coverage. However, you must be eligible for benefits in accordance with Article II (i.e., based on Hours Worked) at the time of accidental death or dismembering injury in order to qualify for these benefits. These benefits are described in detail in Article XII of this SPD.

IV. THE HEALTH NET OF CALIFORNIA PLAN
(You Must Use Network Providers)

Internet (information about Health Net network providers)
http://www.healthnet.com

Health Net's Customer Contact Center (8:00AM to 6:00PM Monday through Friday):
(800) 522-0088 (TTY: 711)

SIMNSA Network (FOR SERVICES IN MEXICO):
(011-52-664) 683-29-02 or 683-30-05 or 1-800-424-4652

IMPORTANT (PLEASE READ): The information in this booklet describing the Health Net of California, Inc. Plan (also referred to as the "Health Net Plan") is for your convenience and is not intended to be a complete description of the Health Net Plan. *For detailed information about the Health Net Plan, including information on covered services, cost sharing, exclusions and limitations, and the procedures for filling claims and appeals, please refer to Health Net's Evidence of Coverage (the "EOC"), which has been prepared by Health Net specifically for the Fund. If there is a conflict between any description of Health Net benefits in this booklet and the Health Net's EOC or the Fund's contract or policy with Health Net, the EOC or the contract or policy with Health Net will control. Please call Health Net at the telephone number listed on the Reference Chart at the beginning of this booklet for a copy of the EOC.*

1. ABOUT THE HEALTH NET OF CALIFORNIA, INC. PLAN

The Health Net of California, Inc. Plan is an HMO medical plan provided by Health Net, Inc., which has contracted with the Fund to provide you and your Dependents with comprehensive healthcare coverage, including medical, hospital, mental/behavioral health, and substance abuse benefits. *(The Health Net Plan does not provide coverage for outpatient prescription drugs. For information on prescription drug coverage, please see "The Prescription Drug Program Provided Through Express Scripts" under Article VI of this SPD.)*

Service Area. The Health Net Service Area encompasses certain regions in Southern California and Mexico (Baja California within fifty miles of the California-Mexico border). Coverage is generally not provided to enrollees outside of the Health Net Service Area, except in cases of Emergency or Urgently Needed Care.

Network Providers. You must use network providers or there is no coverage, except for the following: (1) Emergency or Urgently Needed Care; (2) referrals to non-network providers (e.g., specialists) when issued by your in-network doctor; and (3) covered services provided by a non-network provider when authorized by the Salud HMO y Mas Network or SIMNSA.

The Health Net Plan offers the following two provider networks:

- The Salud HMO y Mas network in Southern California (referred to as the "Salud Network"); and
- The SIMNSA network in Mexico (the "SIMNSA Network").

Be aware, your network provider might use an out-of-network provider for some services (such as lab work). You should always check to make sure your provider is in either the Salud Network or the SIMNSA Network before you get services.

2. DESIGNATING A PRIMARY CARE PHYSICIAN AND A SALUD NETWORK PHYSICIAN GROUP (CALIFORNIA'S SALUD NETWORK ONLY)

For you and your Dependents who live in California (Salud Network): You and your Dependents who live in California must each designate a Primary Care Physician ("PCP") and a Salud Network Physician Group (also called a "Participating Physician Group") within the Salud Network. Your PCP will work within your Participating Physician Group and provide and coordinate your medical care. Until you make this designation, Health Net designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Health Net at 800-522-0088 or you may call the number shown on the back of your Health Net I.D. Card. You can also visit the Health Net website at www.healthnet.com.

- Your Participating Physician Group must be close enough to your home or workplace to allow for reasonable access to medical care. Note that some Participating Physician Groups may decline to accept assignment of an enrollee whose home or work address is not close enough to allow reasonable access to care.
- You and your Dependents may have different PCPs and different Participating Physician Groups.
- For children, a pediatrician may be designated as the PCP.
- You may change your PCP up to once per month by calling Health Net.
- Until you make a PCP and Participating Physician Group designation, Health Net designates one for you.

For your enrolled Dependents who live in Mexico (SIMNSA Network): There is no requirement to designate a PCP or Participating Physician Group in the SIMNSA Network.

Please call Health Net's Customer Contact Center or SIMNSA if you need a Provider Directory, to request provider information, or if you have questions involving reasonable access to care. SIMNSA Members may contact SIMNSA. You can also visit Health Net's website at www.healthnet.com/providersearch for a list of participating providers.

3. HOW TO OBTAIN CARE

For you and your Dependents who live in California (Salud Network): In general, your PCP and Participating Physician Group will provide or authorize all of the medical care that you receive in California.

- You can call your PCP directly to make an appointment.
- **Specialists.** If you need medical care that your PCP or Participating Physician Group cannot provide, you will need a referral to a specialist or other health care provider from your PCP or Participating Physician Group. Once you get approval to receive specialist services, you can call the specialist's office to schedule an appointment.
- **In Mexico.** You and your Dependents who live in California may also obtain covered

services in Mexico from any contracting Physician Group in the SIMNSA Network.

For your enrolled Dependents who live in Mexico (SIMNSA Network): Your enrolled Dependents who live in the Health Net Service Area in Mexico can go to any contracting Physician Group in the SIMNSA Network.

- They must use SIMNSA providers, except in the case of Emergency or Urgently Needed Care.
- **Specialists.** They do not need a referral or prior authorization to see a specialist. In order to receive care from providers outside the SIMNSA Network, however, they must first obtain authorization from SIMNSA, except for Emergency or Urgently Needed Care.
- **In California.** They may not receive any services in California, except for Emergency or Urgently Needed Care.

A. Triage and/or Screening/24-Hour Nurse Advice Line

If you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the triage and/or screening option. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions 24 hours per day, 7 days per week.

B. Emergency Care

For Emergency Care, you can go to the nearest hospital, regardless of whether the hospital is in network or not, but it is critical that you contact your Salud Network PCP or Physician Group in California, or your SIMNSA Provider in Mexico, as soon as you can after receiving emergency services from others outside your Physician Group. Your Salud Network PCP or SIMNSA Physician Group will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care.

4. BENEFITS & COST SHARING

For detailed information about benefits and cost sharing under the Health Net Inc. Plan, **please refer to the Health Net's Evidence of Coverage,** which is available without charge from Health Net and the Administrative Office.

5. PLAN EXCLUSIONS

For a complete list of the conditions, services, and products that are not covered under the Health Net Plan, please refer to the Plan's Evidence of Coverage, which is available from Health Net or the Administrative Office.

6. CLAIMS AND APPEALS PROCEDURES

All claims and appeals for benefits under the Health Net of California, Inc. Plan must be submitted to Health Net and will be processed in according to Health Net's claims and appeals procedures.

V. THE KAISER HMO PLAN
(Must Use Kaiser Permanente Facilities)

Internet:
http://www/kp.org

Kaiser Permanente Member Services (24 hours, 7 days a week):
(800) 278-3296 (TTY: 711)

IMPORTANT (PLEASE READ): This brief description of the Kaiser HMO Plan is included in this booklet for your convenience. It is not intended to be a complete description of the Kaiser HMO Plan. *For detailed information about the Kaiser HMO Plan, including information on covered services, cost sharing, exclusions and limitations, and the procedures for filing claims and appeals, please refer to the Kaiser Permanente Evidence of Coverage (the "EOC"). If there is a conflict between any description of the Kaiser HMO Plan's benefits contained in this booklet and Kaiser's EOC or the Fund's contract with Kaiser, the EOC or the contract with Kaiser will control. Please call Kaiser Customer Service at the telephone number listed on the Reference Chart at the front of this booklet for a copy of the EOC.*

1. ABOUT THE KAISER HMO PLAN

The Kaiser HMO Plan is an HMO medical plan provided through the Kaiser Foundation Health Plan (Kaiser"), which has contracted with the Fund to provide you and your Dependents with comprehensive health care coverage, including medical, hospital, mental/behavioral health, and substance abuse benefits. *(The Kaiser HMO Plan generally does not provide coverage for outpatient prescription drugs. For information on prescription drug coverage, please see "The Prescription Drug Program Provided Through Express Scripts" under Article VI of this SPD.)*

When you enroll in Kaiser, you must receive services from Kaiser Permanente health care providers at Kaiser facilities. If you do not receive services from Kaiser providers, 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). You can call Kaiser or visit Kaiser's website if you would like to make an appointment or find a Kaiser personal physician.

Generally, you will need a referral from a Kaiser physician to see a specialist. However, you don't need referrals for certain specialties, like obstetrics-gynecology.

If you ever need Emergency Care, you can get care at the Emergency Room of a nearby hospital (even if it is not a Kaiser Hospital), and you do not need a referral or preauthorization.

2. BENEFITS & COST SHARING

For detailed information about benefits and cost sharing under Kaiser HMO Plan, please **refer to Kaiser's Evidence of Coverage** which is available without charge from Kaiser Permanente Customer Service at (833) 574-2273

3. PLAN EXCLUSIONS

For a complete list of the conditions, services, and products that are not covered by the Kaiser HMO Plan, please refer to Kaiser's Evidence of Coverage, which is available from Kaiser.

4. CLAIMS AND APPEALS PROCEDURES

All claims and appeals for benefits under the Kaiser HMO Plan must be submitted to Kaiser and will be processed in according to Kaiser's claims and appeals procedures, which are set forth in Kaiser's EOC.

VI. THE PRESCRIPTION DRUG PROGRAM PROVIDED THROUGH EXPRESS SCRIPTS

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

Detailed information concerning the benefits provided under the Prescription Drug Program provided by Express Scripts are contained in the contract between Express Scripts and the Fund and in other program documents maintained by Express Scripts. If there is any conflict between the description of Prescription Drug benefits contained in this booklet and in the contract between Express Scripts and the Fund, or in other program documents maintained by Express Scripts, the terms of the contract or other governing program document will control.

Prescriptions must be filled at pharmacies contracted with Express Scripts in order to be covered by the Plan. These "contracted" pharmacies are called "network pharmacies." A list of network pharmacies in your area can be found on the Express Scripts Web site at http://www.express-scripts.com or you can call Express Scripts at 1-800-606-5667. Any prescription obtained through a pharmacy not in the Express Scripts network will not be covered, except in case of an Emergency.

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 timely notify Express Scripts that you want to get your maintenance medication from a retail pharmacy. If you want to get your maintenance medication(s) from a retail pharmacy, you must inform Express Scripts of your choice before you need your third refill. Otherwise, you will be required use the home delivery mail order program.

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.

1. RETAIL PHARMACY PROGRAM

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. The Express Scripts prior authorization phone number is (800) 753-2851.

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

6. Retail prescriptions are limited to a 30-day supply. For maintenance medications, you can get up to a 90-day supply using mail order.

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

   Retail (limited to 30-day supply):

   Formulary Generic drugs - $3.00 copayment.
   Brand Name drugs - $6.00 copayment

   The pharmacist will provide generic drug substitution wherever available and allowed by your physician. The pharmacist will inform you when a generic substitution has been made. **If you do not wish a 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 drug will be dispensed, but you will have to pay the full difference in cost between the brand name and the generic drug, plus the applicable copayment.**

Warning: *If you get a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay.*

2. MAIL ORDER PHARMACY PROGRAM (FOR MAINTENANCE DRUGS)

If you are on one or more maintenance drugs (drugs that you expect to take regularly over a period of 45 days or more) you will use the mail order program to get your maintenance medications, unless you timely notify Express Scripts that you choose to receive your maintenance drug(s) from a retail pharmacy.

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 medications (e.g. heart medication, blood pressure medication, diabetes medication, etc.) for less money.

For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. When you are first prescribed a maintenance drug, you may fill the initial prescription, and one refill, at a local retail network pharmacy before you notify Express Scripts of your decision. If you don't inform Express Scripts of your decision, you will be required to use the mail order program.

If you choose to use the mail order program for your maintenance medications, you will save money.

In order to use the mail order program, you or your doctor must send your prescription to Express Scripts. You may call the Administrative Office for additional information and to obtain forms, or log in to http://www.express-scripts.com.
Your copayment when purchasing maintenance drugs through mail order will be:

Mail Order (up to 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 maintenance prescription, if your doctor prescribes this quantity. Your cost is limited to the copayment shown above, 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 supply runs out. After the first order, if your prescription includes refills, you can order your refills by telephone. You can also order refills and transfer medications from retail to mail order through www.express-scripts.com or the Express Scripts phone app.

3. PREVENTIVE CARE MEDICATIONS AND PRODUCTS

Certain preventive care medications (prescription and over-the counter) and products are covered at 100% if prescribed by a physician or other appropriate health care professional. Preventive care medications and products are available without any copayment, subject to restrictions otherwise applicable (must use generic if available, unless generic alternative is medically inappropriate, mail order pharmacy program requirements for maintenance medications). You must have a prescription in order for your preventive care medication or product to be covered, even if the medication or product is available over-the-counter ("OTC").

Preventive care medications and products are subject to change. Here is partial list of covered products and medications (a written prescription is required for coverage):

- FDA-approved generic contraceptive drugs and devices for women (subject to quantity limits).
- Preparation products for colon cancer screening test.
- Breast cancer prevention drugs - Risk reducing medications such as tamoxifen, soltamox or raloxifene for women 35 years or older with increased risk for breast cancer and at low risk for adverse medication effects.
- Tobacco cessation products - FDA-approved generic tobacco cessation medications (including both prescription and over-the-counter medications) for up to two 90-day treatment regimens per calendar year.

- Statin preventive medication - Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.

Please contact the Administrative Office if you would like information as to whether a specific medication or product is covered under the Plan's preventive care benefits.

4. COST SHARING LIMIT FOR PRESCRIPTION DRUGS

Your cost sharing for prescriptions filled through Express Scripts is subject to an annual limit.

As of January 1, 2019, the annual cost sharing limit for Express Scripts is $750 per individual and $1,500 per family. *Cost sharing* includes deductibles, copayments, coinsurance, or similar charges, and any other expenditure for any covered drug. Cost sharing does *not* include premiums or spending for non-covered drugs (such as drugs not purchased from an Express Scripts network or mail order pharmacy), nor does it include the cost difference between a name-brand drug and a generic medication.

The amount of the annual limit may be adjusted annually. You will be notified if the cost sharing limits change in later years.

Covered Items:

- Federal Legend drugs
- State Restricted drugs
- Compounded prescriptions (subject to limitations described below under Special Rules for Compound Drugs)
- Insulin
- Federal Legend Non-Drugs
- Syringes, Needles and Devices
- Accutane, through age 24 only
- Tretinoin, ages 19 through 24 only

5. 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 investigational, 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, it will not be considered reasonable). Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under the Plan.

6. SPECIAL PROGRAMS PROVIDED BY EXPRESS SCRIPTS

The Diabetes Care Value Program. The Diabetes Care Value (DCV) Program is an optional program for qualifying Employees and Dependents. Under this program, the patient is provided with a free Bluetooth-enabled blood glucose meter.

The Pulmonary Care Value Program. The Pulmonary Care Value (PCV) Program is an optional program for qualifying Employees and Dependents. Under this program, the patient is provided with a free Bluetooth-enabled short-acting inhaler that logs the patient's use. There are clinical interventions when overuse is identified.

The Cardiovascular Care Value Program. The Cardiovascular Care Value (CCV) Program is an optional program for qualifying Employees and Dependents to assist with the management of high cholesterol.

7. EXCLUSIONS:

The Prescription Drug Program and the Fund do not pay benefits for the following:

- Formulary Excluded Drugs (drugs excluded from coverage by Express Scripts).
- Non-Federal Legend Drugs, Non-Federal Legend Non-Drugs
- Over-the-Counter Drugs (except OTC drugs covered as preventive care)
- Compound drugs that contain any excluded ingredient or are not reasonable in price (See Special Rules for Compound Drugs).
- Durable Medical Equipment
- Hemopoetic Agents
- Nicotine Patches (except to the extent covered as preventive care)
- Abortifacients (including Mifeprex)
- Accutane (above age 24)
- Depigmentation Agents
- Injectable Cosmetics
- Legend Hair Growth Agents
- 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 (these may be covered by your medical plan).
- Investigational or experimental drugs, except as part of an approved clinical trial
- 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. THE DENTAL CARE PLAN PROVIDED BY UNITED CONCORDIA

The Dental Care Plan is a Dental HMO plan provided by United Concordia. Enrollment in this plan is available to all eligible Employees and their Dependents. You must enroll yourself and your Dependents using United Concordia's enrollment form in order to have dental insurance coverage.

The "Schedule of Benefits," issued by United Concordia, describes covered dental services and procedures and applicable copayments. The Dental Care Plan covers only services and procedures listed on the "Schedule of Benefits," when provided by a participating dental provider identified in the "Concordia Plus DHMO Directory of Participating Dental Providers." **Services and procedures provided by non-participating dental providers are not covered under the Dental Care Plan**. To obtain copies of the "Schedule of Benefits" and the "Concordia Plus DHMO Directory of Participating Dental Providers," please contact the Administrative Office.

In addition to United Concordia's Schedule of Benefits, its Evidence of Coverage and Schedule of Exclusions and Limitations (collectively "Dental Care Plan Documents") provide a complete description of your Dental Care Plan provided by United Concordia. You can obtain a copy of these documents by contacting the Administrative Office or United Concordia. If there is any conflict between any description of the Dental Care Plan benefits contained in this booklet and the description contained in United Concordia's Dental Care Plan Documents, the Dental Care Plan Documents will control.

If you have any questions about your benefits under the Dental Care Plan, please call the United Concordia Customer Service Department toll free at (866) 357-3304, or visit the United Concordia Web site: https://www.unitedconcordia.com/dental-insurance/member/.

You may choose to opt out of (or drop) Fund provided dental insurance by contacting the Administrative Office and completing the appropriate form.

VIII. THE DELTA DENTAL PPO PLAN

The Delta Dental PPO Plan is an insured dental plan provided by Delta Dental. Enrollment in this plan is available for all eligible Employees and their Dependents who meet the requirements shown in Section 3.B. of Article III.

A summary of your benefits under the Delta Dental PPO Plan is available in a "Plan Benefits Highlights," issued by Delta Dental. For a copy, please contact the Administrative Office.

Under the Delta Dental PPO Plan, you can visit any licensed dentist. **However, your out-of-pocket costs will be less if you go to a Delta Dental PPO dentist.** Delta Dental PPO dentists have agreed to charge lower rates and can't balance bill you for additional fees. You can find a Delta Dental PPO dentist by visiting deltadentalins.com or by calling (800) 765-6003.

Detailed information on covered benefits and other rules for the Delta Dental PPO Plan are described in Delta Dental's "Combined Evidence of Coverage and Disclosure Form" for the Santa Monica UNITE-HERE Health Benefit Fund. This Combined Evidence of Coverage and Disclosure Form and the Delta Dental PPO^{SM} Group Dental Service Contract between the Fund and Delta Dental of California (collectively "Delta Dental Plan Documents") provide a complete description of benefits under the Delta Dental PPO Plan. If there is any conflict between any description of the Delta Dental PPO Plan benefits contained in this booklet and the description contained in the Delta Dental Plan Documents, the Delta Dental Plan Documents will control.

You can obtain a copy of these documents by contacting the Administrative Office or by calling Delta Dental's Customer Service Department.

If you have any questions about your benefits under the Delta Dental PPO Plan, please call the Delta Dental Customer Service Department toll free at (800) 765-6003, or visit the Delta Dental Web site at deltadentalins.com.

You may choose to opt out (or drop) Fund provided dental insurance coverage by contacting the Administrative Office and completing the appropriate form.

IX. THE VISION SERVICE PLAN BENEFIT PROVIDED BY VISION SERVICE PLAN, INC. (MATERIALS ONLY)

IMPORTANT (PLEASE READ): This brief description of the Vision Service Plan Benefit (the "VSP Benefit") is included in this booklet for your convenience. This booklet does not contain a complete description of the VSP Benefit. *For detailed information about the VSP Benefit, please refer to the Evidence of Coverage ("EOC"), available by calling the Administrative Office. If there is a conflict between any description of the VSP Benefit contained in this booklet and VSP's EOC or the Fund's contract with VSP, the EOC or the contract with VSP will control. Please call VSP at the telephone number listed on the Reference Chart at the front of this booklet for a detailed benefit summary or call the Administrative Office for a copy of the EOC.*

Effective January 1, 2020, the Fund will begin offering a separate vision benefit through Vision Service Plan, Inc. ("VSP").

The Vision Service Plan Benefit (the "VSP Benefit") will provide benefits for frames and lenses (or contacts) as described in this section. In order to have this coverage, you must be enrolled for medical coverage under one of the Fund's HMO plans.

To use this benefit, you must first have a vision exam and get a prescription for eyeglasses or contact lenses. **If you are enrolled in one of the Fund's HMO medical plans, you can get your vision exam and prescription through your HMO plan**.

You will then bring your vision prescription to any VSP network doctor to obtain glasses or contact lenses. Below is a chart that summarizes the benefits available if you use a VSP network doctor.

The VSP Benefit provides out-of-network benefits. However, if you use an out-of-network provider (i.e., a doctor that is not contracted with VSP), benefits will be limited, and you will need to call VSP or the Administrative Office for information about benefits.

VSP has an extensive network of doctors throughout the United States. For a list of VSP doctors, call VSP at (800) 877-7195 or visit their website at vsp.com.

Once you have located a VSP doctor, you can call the doctor's office directly in order to make an appointment. There are no ID cards necessary or claim forms to complete when using a VSP doctor; simply inform the doctor that you're a VSP member.

With the VSP Benefit, lenses and frames are provided as follows:

Eyeglass Lenses:	Every 24 months
Frames:	Every 24 months

An allowance for contact lenses is available every 24 months in lieu of glasses.

IN-NETWORK BENEFITS
(Using a VSP Contracted Provider)

Benefit	**Participant Cost**
Exam	Not Covered. (Covered through your Fund provided HMO plan (Health Net or Kaiser).
Standard plastic lens: Single vision Bifocal Trifocal	 $0 copay $0 copay $0 copay Options such as UV coating, tint, anti-reflective coating and polycarbonate lenses are available for an additional charge.
Standard Progressive lenses	$0 copay
Premium Progressive Lenses	Premium: $95-$105 Custom: $150-$175
Lens Options: UV Coating	 $10-$16 copay
Tint (solid and gradient)	$0 copay
Standard polycarbonate	$31 copay ($35 if multifocal lens)
Standard anti-reflective coating	$41 copay
Other add-ons	Most lens enhancements are covered with fixed copays, saving participants an average of 25%. All other lens enhancements receive a 20% discount.
Frames: Basic	 Participant pays 80% of cost above $120 allowance
Featured Brands	Participant pays 80% of cost above

IN-NETWORK BENEFITS
(Using a VSP Contracted Provider)

Benefit	**Participant Cost**
	$140 allowance
Contact Lenses: *Coverage for contact lenses is in lieu of benefits available for glasses.* Conventional or Disposable	Participant pays 100% of cost above $120 allowance for lenses available every 24 months. Up to $60 copay for contact lenses fitting exam.
Medically necessary contact lenses	$0 copay
Laser vision correction: Lasik or PRK	Participant pays 85% of retail cost
Additional Pairs of Glasses	Participant pays 80% of retail cost

The VSP Benefit is automatically included if you enroll for medical coverage under one of the Fund's HMO plans. You may choose to opt out of the VSP Benefit by contacting the Administrative Office and completing the appropriate form. You will get no advantage by opting out of VSP coverage.

X. THE MEMBER ASSISTANCE PROGRAM (MAP) PROVIDED BY BEACON HEALTH OPTIONS

Telephone: 1-(888) 479-6606

The Member Assistance Program (the "MAP"), administered by Beacon Health Options, Inc. ("Beacon"), provides information, guidance, and support to help you and your family reach your personal and professional goals, manage daily stresses, and develop fulfilling relationships. In addition to this brief description of the MAP, a separate pamphlet prepared by Beacon is available from the Administrative Office.

The MAP provides you and each of your enrolled Dependents three (3) free and confidential visits per year (whether in person or via telephone or video) for 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. In addition, MAP offers 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. The MAP is administered by:

Beacon Health Options, Inc.
P.O. Box 6065
Cypress, California 90630-0065
(888) 479-6606

To access MAP services or if you have questions about the MAP, call Beacon at (888) 479-6606 (24 hours a day, 7 days a week) or visit www.achievesolutions.net/santamonicauhh.

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

XI. LIFE INSURANCE BENEFITS

Life Insurance benefits are provided directly by the Fund in the amount of $20,000.

When proof of your death is received by the Administrative Office, the Life Insurance benefit will be paid to your beneficiary, in accordance with this Article XI. When proof of your Dependent's death is received by the Administrative Office, the Life Insurance benefit will be paid to you (the Employee).

Only eligible Employees and their Dependents, as defined in Article I, are covered for Life Insurance benefits. Life Insurance coverage ends when eligibility ends under Article II, except that eligibility for Life Insurance does not continue during periods of extended eligibility due to disability under Article II, Section 8 or COBRA.

1. BENEFICIARY FOR EMPLOYEE LIFE INSURANCE

You may designate one or more beneficiaries to receive the Life Insurance benefit upon your death, or change any beneficiary designation, at any time, by submitting a written beneficiary designation notice to the Administrative Office using a form approved by the Fund. Any designation or change will take effect after it has been received by the Administrative Office, provided benefits have not been paid before it was received. Additionally any designation or change of beneficiary must be received by the Administrative Office before your death to be effective.

If you designate more than one beneficiary, but do not state amounts or order of payment, benefits will be equally divided among your designated beneficiaries.

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

If you have no designated beneficiary at the time of your death, or if your designated beneficiaries all predecease you, benefits will be paid to the member(s) of the first surviving class as follows:

1. Your legal spouse or Domestic Partner;
2. Your children and the covered children of your 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 that the Plan makes in good faith under these provisions will discharge the Plan's liability to the extent of the payment.

XII. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Accidental Death & Dismemberment benefits are provided directly by the Fund. Only eligible Employees, as defined under Article I, are covered for Accidental Death & Dismemberment benefits. Accidental Death & Dismemberment benefits are not available for the accidental death or injury of a Dependent.

Accidental Death & Dismemberment coverage ends when eligibility ends under Article II, except that eligibility for Accidental Death & Dismemberment benefits does not continue during periods of extended eligibility due to disability under Article II, Section 8, or while you are covered under COBRA.

When proof of your accidental death is received by the Administrative Office, and your accidental death occurs within 90 days after and as a direct result of an accident, the Accidental Death and Dismemberment benefit for loss of life is paid to your named beneficiary. You may name or change any beneficiary at any time by filing a written notice with the Administrative Office using a form approved by the Fund. The beneficiary rules set forth in Article XI, under "Beneficiary for Employee Life Insurance," apply to payment of the Accidental Death benefit.

When, within 90 days after and as a direct result of an accidental injury, you sustain one of the losses listed below (other than loss of life), and proof of such loss is received by the Administrative Office, a dismemberment benefit will be paid to you.

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 benefit 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 or as the result of any one accident. All claims must be received within one year of death or accidental injury or benefits will not be payable.

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

Accidental death means death resulting from an external, violent and unexpected means and includes death by homicide.

Accidental injury means bodily injury resulting from an external, violent and unexpected means.

1. EXCLUSIONS

This Accidental Death & Dismemberment Benefit does not cover the following:

1. Loss caused by war or any act of war.

2. Loss occurring during air travel.

3. Loss caused by suicide or any attempt at suicide.

4. Loss which occurs while the covered person is committing a felony.

5. Loss due to disease or bacterial infection (except pus-forming infection occurring with an accidental wound)

6. Loss due to diabetes or any sickness attributable to diabetes.

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

XIII. EXTENDED COVERAGE
(FOR MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, AND MAP BENEFITS)

1. EXTENSION OF COVERAGE UNDER 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. **COBRA coverage is not provided free of charge; 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, but it does not include Life Insurance or Accidental Death and Dismemberment benefits. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as Employees and Dependents with active medical coverage under the Plan, including Open Enrollment and Special Enrollment rights. **However, qualified beneficiaries do not have coverage for Life Insurance or Accidental Death and Dismemberment benefits 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 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

A. 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, Section 8).

B. 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. 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 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 or call 1-800-300-1506.

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

C. 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.

D. Electing COBRA Coverage

Within 45 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, prescription drug, and MAP), a Core-Plus Dental plan of benefits (Core-Only plus dental), a Core-Plus Vision plan of benefits (Core-Only plus VSP), and a Core-Plus Dental & Vision plan of benefits (Core-Only plus dental and VSP). All qualified beneficiaries in one family unit are not

required to elect the same plan of COBRA benefits (Core-Only, Core-Plus Dental, etc.). However, all family members must be in the same medical plan (Health Net or Kaiser) under which they were eligible on the day before the occurrence of the qualifying event.

Each qualified beneficiary is allowed to change medical plans on the same basis as Employees and Dependents with active Plan coverage (e.g., during Open Enrollment). COBRA coverage does not include Life Insurance or Accidental Death & Dismemberment benefits.

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 may 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 Fund 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/former 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.

E. Adding Dependents to COBRA Coverage

A child who is born to, adopted by, 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.

In contrast, a new spouse/Domestic Partner or a child who is not a newborn or new adoptee of the Employee can be added to COBRA coverage, but is not a qualified beneficiary with independent COBRA rights. If the 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 thirty (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.

F. Payment Requirements

Each qualified beneficiary must pay the full cost of COBRA coverage by paying a monthly premium to the Administrative Office. As provided under federal law, monthly COBRA premiums 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 premium payment must be postmarked within forty-five (45) days of the date the COBRA election was made (this is the date the completed and signed COBRA election form is post-marked, if mailed to the Administrative Office). 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 the Administrative Office to confirm the correct amount of the first payment. COBRA coverage will not be effective until the first payment is received.

Subsequent premium 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 thirty-one (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. Health Benefit Trust Fund and remitted to the Administrative Office.

No benefit claim will be honored unless the required premium 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 for.

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.

G. 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. 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 within 30 days after the date of the final SSA determination that the qualified beneficiary is no longer disabled. 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 Dependent child status under the Plan, COBRA coverage for the affected spouse, Domestic Partner, and/or child may be extended up 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.

H. 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 generally became 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.

2. EXTENSION OF COVERAGE UNDER CAL-COBRA

The California Continuation Benefits Replacement Act ("Cal-COBRA") supplements federal COBRA by requiring HMOs 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 your federal COBRA coverage first started.

This Cal-COBRA extension is only available to COBRA enrollees 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 the HMO plan in which you are enrolled and can cost up to 110% (150% for the disability extension) of the applicable group rate. You must contact Health Net or Kaiser 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 maximum COBRA coverage 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 Health Net or Kaiser in writing within 30 calendar days prior to the date your federal COBRA coverage is scheduled to end.

Please refer to the Health Net or 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 Health Net or Kaiser directly.

3. MEDICAL CONVERSION

When extended coverage (either COBRA or Cal-COBRA) has been exhausted, you and/or your covered Dependents may be entitled to convert from the Fund's group HMO plan to an individual conversion policy with your HMO as set forth in the medical conversion provision of the group policy. If you want this conversion coverage, contact Health Net or Kaiser immediately after the termination of your continued coverage, as you only have a limited time to apply for it.

You and your family members may also have options available under the Affordable Care Act through the Health Insurance Marketplace (also known as the Exchange). Generally, you can only enroll in Marketplace coverage: (1) within 60 days after your loss of Plan coverage (including exhaustion of COBRA or Cal-COBRA); (2) during a Marketplace annual open enrollment period; or (3) if you qualify for a Special Enrollment Period due to a life event such as marriage or the birth of a child. 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 or call 1-800-300-1506. If you live outside of California, more information about health insurance options is available at www.healthcare.gov or call 1-800-318-2596.

XIV. OTHER RIGHTS AND OBLIGATIONS UNDER THE PLAN

1. 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 may 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.

2. 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 Dependents 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 in accordance with USERRA if: (1) such coverage was terminated as a result of uniformed service; (2) the Employees are reemployed following completion of such service within the timeframes required by USERRA; and (3) other requirements of USERRA are satisfied.

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

3. WORKING EMPLOYEES AND DEPENDENTS ELIGIBLE FOR MEDICARE (DENTAL, LIFE INSURANCE, AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS NOT AFFECTED)

Medicare beneficiaries may choose to retain or drop medical coverage, including prescription drug benefits, under this Plan.

- If you or one of your Dependents choose to retain your Plan coverage, your Fund coverage will generally be primary and will continue to provide you the same coverage provided to other active Employees and their covered Dependents. Medicare may then provide additional or secondary coverage.

- If you or a Medicare Eligible Dependent wants Medicare to be primary, you or your Dependent may choose to drop your Fund medical coverage, and Medicare will be primary. However, if you make this choice, you will not have any medical coverage (including vision and prescription drug benefits) from this Plan. The only coverage you can retain from this Plan is Life Insurance, AD&D Benefits, and Dental insurance.

The choice of retaining or dropping Plan medical coverage is solely your responsibility. Neither the Fund nor your Employer will provide any consideration, incentive, or benefits to encourage dropping Plan coverage. If you are the covered Employee, and you drop your medical coverage under the Plan, your Dependents will also lose their medical coverage under the Plan.

Note: Voluntarily dropping Plan coverage is not a COBRA qualifying event. Therefore, if a Medicare beneficiary voluntarily drops his or her Plan coverage (for instance, during Open Enrollment), he or she will not be entitled to COBRA Coverage, since choosing to drop Plan coverage is not a COBRA Qualifying Event.

IF YOU WANT MEDICARE AS YOUR PRIMARY COVERAGE, YOU MUST SUBMIT A WRITTEN STATEMENT TO THE PLAN REJECTING YOUR COVERAGE UNDER THE PLAN IN FAVOR OF MEDICARE. UNDERSTAND THAT YOU WILL GET NO ADVANTAGE FROM THE FUND FOR MAKING THIS DECISION.

4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

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 Dependent 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, that has the force and effect of law in that state, which meets the requirements of Section 609 of ERISA.

If the Administrative Office receives a QMCSO, the child(ren) identified in the QMCSO will be enrolled in the Plan as your Dependent(s), provided that they are otherwise eligible for coverage under the Plan. The child's custodial parent, legal guardian, or a state agency can make application for Plan 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.

5. 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, coinsurance and copayments applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, call your HMO or the Administrative Office.

6. HOSPITAL STAY FOLLOWING CHILDBIRTH

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

7. NOTICE OF PATIENT PROTECTIONS & CHOICE OF PROVIDERS (HEALTH NET)

For Health Net Plan Enrollees who live in California: The Health Net Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Health Net designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Health Net at 800-522-0088 or you may call the number shown on the back of your Health Net I.D. Card. You can also visit the Health Net website at www.healthnet.com.

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

You do not need prior authorization from Health Net or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Salud HMO y Mas network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call Health Net at 800-522-0088 or call the number on the back of your Health Net I.D. Card.

For Health Net Plan enrollees who live in Mexico: HealthNet enrollees who live in Mexico do not need to select a PCP and can visit any provider in the SIMNSA network.

8. NOTICE OF PATIENT PROTECTIONS & CHOICE OF PROVIDERS (KAISER)

For Kaiser Permanente Enrollees: Personal physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

Kaiser Permanente encourages you to choose a personal physician. You may choose any available personal physician. Parents may choose a pediatrician as the personal physician for their child. Most personal physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal physicians.

To learn how to select a personal physician, please refer to the Getting Started brochure, Your Guidebook, or call Kaiser's Member Service Call Center. You can find a directory of plan physicians on Kaiser's website at kp.org. For the current list of physicians that are available as personal physicians, please call the personal physician selection department at the phone number listed in the Getting Started brochure or in Your Guidebook. You can change your personal physician for any reason.

You do not need a referral or prior authorization from any person (including a personal physician) in order to obtain access to obstetrical or gynecological care from an in-network Kaiser health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Please see your Evidence of Coverage for more information.

XV. CLAIMS AND APPEALS PROCEDURES

For purposes of these Claims and Appeals Procedures, the term "you" or "yours" refers to any covered Participant in the Plan (i.e, covered Employees and covered Dependents).

1. APPLICABILITY

A. These claims and appeals procedures apply to the following:

- Claims and appeals for Life Insurance and Accidental Death & Dismemberment benefits provided by the Plan.
- Disputes concerning eligibility determinations that are unrelated to any specific Claim for a Plan benefit and that are not rescissions, including appeals regarding eligibility for coverage under the Plan (including COBRA coverage).
- Disputes concerning rescissions of Plan coverage that are unrelated to any specific Claim for a Plan benefit.
- Claims denials involving a determination of disability under Article II, Section 8 of this SPD (for "Extended Eligibility for Disability Credit").

B. These procedures do **not** apply to the following benefits:

- Medical benefits provided through the Health Net or Kaiser HMO plans
- Prescription Drug benefits provided through Express Scripts
- Dental Insurance provided though United Concordia or Delta Dental
- Member Assistance Program (MAP) benefits provided though Beacon Health Options

Claims (and appeals) for these benefits must be submitted to the organization (generally the HMO or the insurance company) providing the benefit and will be processed in accordance with that organization's claims and appeals procedures, which are described in separate documents issued by the organization. You may obtain the claims and appeals procedures by contacting the organization (or you may contact the Administrative Office for assistance). For example, if you are enrolled in Health Net, an appeal for medical benefits must be submitted to Health Net and will be processed in accordance with Health Net's claims and appeals procedures, which can be obtained by calling Health Net's customer service department.

2. GENERAL RULES

What is a Claim? A Claim is a request for benefits submitted by you or your Authorized Representative in accordance with these claims and appeals procedures. A Claim is not: (1) a mere request for information about plan benefits; or (2) a dispute concerning eligibility for plan benefits, including COBRA coverage, that is unrelated to any specific Claim.

Authorized Representative. You may designate an "Authorized Representative" to act on your

behalf in filing a Claim or appeal or requesting an external review. Your designation must be in writing on a form acceptable to the Board of Trustees. An Authorized Representative designation will be valid until it is revoked or otherwise expires. You may revoke a designation at any time by submitting a written request to revoke the designation to the Administrative Office. *Any reference to "you" in these claims and appeals procedures also includes your designated Authorized Representative*.

Requirement to Exhaust the Plan's Internal Claims and Appeals Procedures. An Employee or the Employee's covered Dependent must first exhaust the Plan's internal claims and appeals process before filing a civil action under ERISA Section 502(a) against the Plan or the Board of Trustees. This means that before you may take legal action, you must follow all of the applicable procedures for filing an internal claim and an appeal as described in this document.

Failure to Follow Procedures. If the Plan fails to substantially follow these claims and appeals procedures, and it does not correct the error without prejudice to you, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).

Limitation on When a Lawsuit May Be Filed. You may not commence a lawsuit or other legal action to obtain Plan benefits until after all administrative procedures have been exhausted (including the exhaustion or deemed exhaustion of this Plan's claims and appeals procedures), for every issue relevant to a Claim for benefits under the Plan. However, you are not required to exhaust the Plan's external review process before seeking a judicial remedy for claims involving a rescission.

No lawsuit may be filed (started) more than three (3) years after the end of the year in which services were provided.

Authority of the Board. 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.

3. LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

The following claims and appeals procedures apply to Claims for Life Insurance and Accidental Death & Dismemberment benefits provided directly by the Fund, which are described in Articles XI and XII of this SPD.

A. Filing a Claim

To file a Claim, you or your beneficiary must submit a written request for a benefit to the Administrative Office, along with any required supporting documentation (such as a death certificate). Claims for Life Insurance benefits must be filed within one year after the date of death. Claims for Accidental Death & Dismemberment benefits must be filed within one year from the date of loss resulting from the accident. Claims filed after these deadlines will be denied. A Claim is considered filed on the date it is received by the Administrative Office (or on the date postmarked, if mailed to the Administrative Office through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

B. Processing a Claim

You will be notified, in writing, of the Plan's decision within 90 days after your Claim is filed. This 90-day period may be extended by up to an additional 90 days if special circumstances require an extension of time for processing. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. You can always allow the Plan to take more time to process your Claim.

If your Claim is denied, in whole or in part, you will receive a denial notice that: (a) states the specific reason(s) for the denial; (b) refers to the specific Plan provision(s) on which the denial is based; (c) describes any additional material or information necessary for you to perfect your Claim and explains why such material or information is necessary; (d) describes the Plan's internal appeal procedures, including the time limits applicable to such procedures and information on how to file an appeal; (e) states that you are entitled to receive, upon request, free access to and copies of documents relevant to your Claim; and (f) states your right to bring a civil action under ERISA Section 502(a) following the denial of your Claim on appeal.

C. Filing an Appeal

If you believe you have been denied a benefit improperly, or received a benefit less than the benefit to which you are entitled, you may submit a written request to the Board of Trustees asking for a review of the denial (this is called an "appeal").

Your appeal must be filed with the Administrative Office within 180 days after you receive the written denial notice. An appeal is considered filed on the date it is received by the Administrative Office (or on the date postmarked, if mailed to the Administrative Office through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Your appeal must be in writing and include your name, mailing address, telephone number, and the basis for your appeal. You may submit any written comments, documents, records, evidence, testimony, and other information relating to your Claim to support your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim.

D. Processing an Appeal

Your appeal will receive a full and fair review by the Board of Trustees. The Board will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you that relates to your Claim, regardless of whether such information was submitted or considered in the initial review. You have no right to appear personally before the Board. The Board will exercise its reasoned discretion and authority in making, interpreting, and applying Plan rules, and in resolving any appeals. The Board's decision will be conclusive and binding upon all persons and for all purposes.

Your appeal will be decided at the Board meeting that occurs at least 30 days after the date the appeal is filed. The time for deciding your appeal may be extended to the third meeting after the appeal is filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information necessary to make a determination on the appeal. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide the appeal, you will be given at

least 45 days to respond, and the time for the Board's decision will be suspended from the date of the extension notice until the earlier of the date you respond or the due date set by the Board. You may voluntarily agree to extend the time for the Board to process your Claim. You will be provided with a written notice of the decision within 5 days after the Board makes its decision.

If a your Claim is denied on appeal, you will receive a denial notice that: (a) states the specific reason(s) for the denial; (b) refers to the specific Plan provision(s) on which the denial is based; (c) states that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim; and (d) states your right to bring an action under ERISA Section 502(a).

4. DISPUTES CONCERNING ELIGIBILITY DETERMINATIONS

If you believe that you or your Dependents have improperly been denied enrollment or eligibility for any benefit under the Plan, but you don't have a Claim for a specific benefit and there has not been a rescission of coverage (as defined in Article II, Section 11), you may submit a written request to the Board of Trustees asking for a review of the denial (this is called an "appeal").

The appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3.C. ("Filing an Appeal") and Section 3.D. ("Processing an Appeal") of this Article XV, will apply, except that you have 60 days after you receive a written denial notice to file your appeal with the Administrative Office, and you will be provided with a written notice of the decision within 20 days after the Board makes its decision.

5. DISPUTES CONCERNING RESCISSIONS OF COVERAGE

If you believe that Plan coverage for you or your Dependent has been improperly rescinded (i.e., terminated retroactively) under Section 11 of Article II of this SPD, you may submit a written request to the Board of Trustees asking for a review of the rescission.

A. Additional Procedures for Rescissions

The appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3.C. ("Filing an Appeal") and Section 3.D. ("Processing an Appeal") of this Article XV, will apply, subject to the following exceptions:

i. Your appeal must be filed within 180 days after you receive the written rescission notice.

ii. You will be automatically provided, free of charge, the following: (a) any new or additional evidence considered, relied upon, or generated in connection with the decision to rescind your coverage; and (b) any new or additional rationale for a denial upon appeal. This information will be provided as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered. If applicable, you will be provided, upon request and free of charge, the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the decision to rescind your coverage, regardless of whether the advice was relied upon in making the determination.

iii. The Board of Trustees, which is neither the entity that made the initial decision to rescind your coverage nor the subordinate of such entity, will make an independent determination and will not afford deference to the initial review.

iv. The Board's decision will be conclusive and binding upon all persons and for all purposes, except in the limited circumstance that your dispute is submitted to the external review process, in which case the decision of the IRO will be final.

v. The appeal denial notice will also include the following: (a) a statement of your right to request an external review by an independent review organization, including a description of the external review process; (b) a statement of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the external review process; and (c) a statement of your right to bring a civil action under ERISA Section 502(a) following the denial of your request on appeal or under the Plan's external review process.

B. Recourse after Denial on Appeal

If your appeal is denied, in whole or in part, you have the following options: (i) you may submit your dispute to the external review process; (ii) you may bring an action under ERISA Section 502(a); or (iii) you may bring an action under ERISA Section 502(a) after exhausting the external review process.

C. External Review

External review is conducted by an accredited independent review organization ("IRO") that is independent of the Plan and the Board of Trustees. When you request an external review of a rescission, the Plan will turn over all related information to the IRO conducting the external review. There is no cost to you for requesting external review.

To request an external review of the Plan's decision to rescind your coverage, you must submit a written request to the Administrative Office within 4 months of receiving the appeal denial notice (or, if a decision on appeal has not yet been reached because you are deemed to have exhausted the administrative remedies available under the Plan, within 4 months of receiving the notice of rescission).

When it receives your request, the Administrative Office will conduct a preliminary review to determine whether your request is eligible for external review, and will notify you in writing of its determination within 6 business days.

If your request is eligible for external review, the Administrative Office will assign your request to an IRO. The IRO will notify you in writing of the request's eligibility and acceptance for external review.

The Administrative Office will provide the IRO with any documents and information that was considered in connection with the rescission within 5 business days after your external review request has been assigned to the IRO. If the Administrative Office fails to comply with this requirement, the IRO may terminate the external review and reverse the Plan's decision, in which

case the IRO will notify you and the Administrative Office within one business day of making its decision.

Within 10 business days after receiving the IRO's notice, you may submit additional written information regarding the dispute to the IRO, which the IRO will consider when conducting its review and will forward to the Administrative Office within one business day of receipt. Upon receipt of the additional information, the Board of Trustees (or the Appeals Committee) may reconsider its decision to rescind your coverage. Such reconsideration, however, will not delay the external review. If, upon reconsideration, the Board of Trustees (or Appeals Committee) reverses its decision, it will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

The IRO will review all of the information and documents timely received. In addition, the IRO may consider additional, appropriate information. In reaching a decision, the IRO will review the Trustees' determination as if it is new and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedures. However, the IRO will be bound to observe the terms of the Plan, unless the terms of the Plan are inconsistent with applicable law.

The IRO will notify you and the Administrative Office in writing of its decision within 45 days after receiving your external review request. The IRO's notice will contain the following: (a) a general description of the reason for the external review request; (b) the reason for the previous denial; (c) the date the IRO received the request and the date of its decision; (d) references to the evidence or documentation considered by the IRO in reaching its decision, including the specific coverage provisions and evidence-based standards; (e) a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision; (f) a statement that the IRO's determination is binding, except to the extent that the dispute is submitted to binding arbitration pursuant to applicable State law; and (g) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

If the IRO reverses the Plan's decision to rescind your coverage, the Plan will provide coverage upon receipt of the IRO's notice. If the IRO upholds the Plan's rescission, you may bring an action under ERISA Section 502(a).

6. CLAIM DENIALS INVOLVING A DETERMINATION OF DISABILITY

If you believe that your Claim was denied because you were improperly denied disability credits under Article II, Section 8 of this SPD ("Extended Eligibility for Disability Credit"), the claims and appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3 of this Article XV, will apply, subject to the following exceptions:

A. The appeal described in Section 3.C. of this Article XV ("Filing an Appeal") must be filed within 180 days after you receive the denial notice.

B. The appeal review procedure described in Section 3.D. of this Article XV ("Processing an Appeal") will also: (a) afford no deference to the initial adverse determination and

provide for a review that is conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial adverse benefit determination or that person's subordinate, (b) for denials based on medical judgment, include consultation with a health care professional who has appropriate training and experience in the field of medicine involved, was not consulted in connection with the initial denial, and is not that person's subordinate, (c) provide, upon request, the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan, and (d) provide, free of charge and sufficiently in advance of the denial date, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim and/or any new or additional rationale for the denial.

C. The appeal denial notice described in Section 3.D. of this Article XV ("Processing an Appeal") will include the following additional information: (a) a discussion of the decision, including an explanation of the basis for disagreeing with or not following any Social Security Administration disability determination, or the views of the health care or vocational professionals presented by you or obtained by the Plan; (b) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you, upon request and free of charge; and (c) the specific internal rules, guidelines, protocols, standards, or similar criteria of the Plan relied upon in making the adverse determination, or, alternatively, a statement that such information does not exist.

XVI. GENERAL PROVISIONS AND INFORMATION ABOUT 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
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(866) 345-5189 or (562) 463-5075
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 Administrative Office.

3. EMPLOYER IDENTIFICATION NUMBER

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

4. TYPE OF PLAN

The Plan is a welfare benefit plan that provides medical, prescription drug, dental, vision, member assistance program, life insurance, and accidental death and dismemberment 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 Benefits

Health Net of California, Inc.
PO Box 9103
Van Nuys, CA 91410
(800) 522-0088

Kaiser Foundation Health Plan, Inc.
3100 Thorton Ave.
Burbank, CA 91504
(818) 557 - 3968

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

For Dental Insurance

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

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
800-765-6003

For Member Assistance Program ("MAP") Benefits

Beacon Health Options, Inc.
P.O. Box 6065
Cypress, CA 90630-0065
(888) 479-6606

6. NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR

Board of Trustees of the Santa Monica UNITE HERE Health Benefit Trust Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(866) 345-5189 or (562) 463-5075

7. NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

The Board of Trustees has appointed the following as its agent for service of legal papers:

Richard D. Sommers, Esq.
Schwartz, Steinsapir, Dohrmann & Sommers, LLP
6300 Wilshire Blvd., Suite 2000
Los Angeles, California 90048-5204

Service of legal process may also be made on a Plan Trustee or the Plan Administrator.

8. NAMES AND ADDRESSES OF TRUSTEES

Employer Trustees

Ms. Teri Serrano
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(866) 345-5189 or (562) 463-5075

Yohanys Lamas Castro
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(866) 345-5189 or (562) 463-5075

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

Karine Mansoorian
(Alternate Trustee)
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Kurt Petersen
(Alternate Trustee)
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

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 Fund. Copies of any Collective Bargaining Agreement may be obtained by Employees and their Dependents upon written request to the Administrative Office and is available for examination by Employees and their Dependent's at the Administrative 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 COBRA coverage.

11. RIGHT TO RECOVER OVERPAYMENTS

Whenever a benefit payment (including premiums for HMO coverage) exceeds the amount that should have been paid (an "overpayment"), the Fund shall have the right to recover the overpayment (plus interest at the same annual rate imposed for delinquent Employer contributions) from any person or organization to, or for, whom said payments were made or from any person whose acts, omissions, or representations caused overpayments. In the event that the Fund brings legal action to recover any such overpayment, the Fund shall be entitled to recover its costs and attorney's fees incurred in such action.

12. FUNDING MEDIUM

All Plan assets are held in the Santa Monica UNITE HERE Health Benefit Trust Fund ("Fund"). Medical, dental, vision, and member assistance program benefits are provided through insurance contracts between the Santa Monica UNITE HERE Health Benefit Trust Fund and various HMOs and insurance companies. For insured benefits, the insurer is responsible for paying claims and providing benefits, not the Fund.

13. PLAN YEAR

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

14. 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 or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them 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 plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, 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).

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If

you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.