SUMMARY PLAN DESCRIPTION

of the

PREMIUM REIMBURSEMENT PLAN FOR RETIREES

of the

SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST

Incl. COBRA General Notice
& HIPAA Privacy Notice

Based on Premium Reimbursement Plan for Retirees,
Amended and restated effective August 1, 2024,
And including Plan Amendment Nos. 1 - 10

Issued and Distributed: August 2024

SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST
PREMIUM REIMBURSEMENT PLAN FOR RETIREES

Summary Plan Description

HIGHLIGHTS OF THE PLAN:

- Eligibility. Generally, Employees[1] need to attain five years of Active Service under the Plan (or ten years of Active Service under the Plan if hired after December 31, 2008), during which time contributions are made to the Trust by the City of Santa Monica on the Employee's behalf; retire or cease employment with the City of Santa Monica after attaining age 50 and becoming eligible for retirement benefits; and attain age 58.
- Benefits. Your benefits from this Trust come in the form of reimbursement for certain medical premiums for coverage after retirement. Your reimbursement amount is limited to the monthly Benefit Amount. The Benefit Amount as of July 1, 2024, and continued through publication of this Summary, is $425 per month, but subject to change.[2]
- Change of Address, Spouse or Children. If you move or change your mailing address, it is your responsibility to update the mailing address on file with the Trust Office. It is also your responsibility to update the Trust Office of any change in spouse (marriage, divorce, domestic partnership) or Children (birth or adoption). Failure to notify the Trust Office may result in loss or delay of benefit payments.
- Trust Office. The Trust Office is a great resource and provides important services to the Trust. For example, to find out the monthly Benefit Amount, submit any benefit claims, or request a copy of the Plan, you can contact the Trust Office at the following:

Santa Monica City Employees Coalition Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor, Los Angeles, CA 90017
E-mail: santamonicacity@bpabenefits.com
Phone: (800) 828-0233

NOTE: The questions and answers in this Summary Plan Description have been designed to provide you with key information about the Santa Monica City Employees Coalition Benefit Trust Premium Reimbursement Plan for Retirees, but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Santa Monica City Employees Coalition Benefit Trust Premium Reimbursement Plan for Retirees," amended and restated August 1, 2024, and as amended thereafter. If there is a conflict between the contents of the Plan and the contents of the Summary Plan Description or any other descriptions, the terms of the Plan will prevail.

[1] Note that capitalized terms contained herein are defined in the formal Plan document.

[2] See Q&A 4 below for a detailed description of the type of expenses for which you will be reimbursed; and Q&A 5 for more details about the monthly Benefit Amount.

PREMIUM REIMBURSEMENT PLAN FOR RETIREES

Summary Plan Description
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SUMMARY PLAN DESCRIPTION

1. Who can participate?

All Employees who are represented by a bargaining unit participating in the Coalition of Santa Monica City Employees participate in the Plan through a Memorandum of Understanding. In addition, Santa Monica City Council members and members of bargaining units that the Board of Trustees has specifically approved for participation, participate pursuant to a Special Agreement (as defined in the Trust Agreement). Participation for all individuals is dependent on the Employer making mandatory contributions to the Trust as required by a Memorandum of Understanding or Special Agreement.

2. Who is eligible for benefits?

An Employee described in No. 1 becomes an Eligible Retiree entitled to benefits under the Plan, generally, after the Employee meets all the following requirements:

- Earns five years of Active Service (or ten years of Active Service for employees hired after December 31, 2008), which is earned through full-time or permanent part-time employment with the City of Santa Monica with contributions to the Trust on the Employee's behalf for all periods of Active Service.

- Attains age 58.

- Retires or ceases employment with the City of Santa Monica after attaining age eligibility for a service retirement with CalPERS. (Return to any employment with the City after retirement will cause a suspension of benefit payments for the length of that re-employment. Benefit payments will resume upon separation from all employment with the City.)

3. What are the benefits from the Plan?

After meeting the eligibility requirements, Eligible Retirees are entitled to monthly reimbursement toward the payment of Premiums, which include health insurance and/or long-term care insurance premiums for coverage effective after becoming eligible for benefits. Reimbursement payments are subject to proper and timely submission of benefit claims and supporting documentation. The amount of an Eligible Retiree's monthly reimbursement payment is limited to the current Benefit Amount.

Cost-Sharing. Also, it is important to remember that the Plan reimburses toward the cost of Premiums, but the Benefit Amount may not cover your entire health insurance premium. If the Benefit Amount does not cover the entire cost of your premium, you will be responsible for the balance of any premiums you owe in excess of the Benefit Amount.

4. What type of premiums will be reimbursed by the Plan?

Insurance premium payments for coverage under health, dental, vision, or pharmacy insurance plans that are tax-deductible medical care under Internal Revenue Service Code

("Code"), Section 213(d). This covers a broad array of health insurance premiums, including premiums for your spouse's plan, individual insurance policies, Medigap policies, Medicare Part A, B and D premiums, dental insurance, vision insurance, and prescription drug policies. In addition, premium payments for long-term care insurance are reimbursable up to the amount qualified as tax-deductible under Code Section 7702B. All premiums must be for insurance coverage in effect after the Beneficiary became eligible for benefits from this Plan.

Beneficiaries may check with the Trust Office to determine if a payment is a permissible reimbursement Premium under the Plan.

5. What is the monthly Benefit Amount?

The Benefit Amount is the maximum monthly amount available to an Eligible Retiree for the reimbursement of Premiums. The Trustees set and periodically adjust the Benefit Amount. Effective July 1, 2024, the Benefit Amount is $425 per month. You may contact the Trust Office to check whether there has been a change to the Benefit Amount.

Adjustments to Benefit Amount. The Trustees reserve the right and power to adjust the Benefit Amount up or down. Such adjustments, or termination of benefits, may apply to some or all current and/or future Beneficiaries. This could occur, generally, after the Trustees conduct a periodic review of the investment and demographic experience of the Trust. That is, if the investment returns or the demographic experience (e.g., life span, retirement age, etc.) are significantly different than projected, then the Benefit Amount may be adjusted (up or down).

6. What happens if I don't use my full monthly Benefit Amount each month?

The Trust Office will not carryover any unused balance of a Beneficiary's monthly Benefit Amount to the next month. (See Q&A 7 for discussion of annual and quarterly premium payments.) You must submit a premium for coverage in effect in that month in order to receive the Benefit Amount for that month. For example, with a $425 monthly Benefit Amount, if a Beneficiary submits a claim for Premiums of $200 for August insurance coverage, the Trust Office will pay the Beneficiary $200 and the remaining $225 will not carryover to reimburse September premium payments, i.e., the September Benefit Amount is still $425 (not $625). To use the $225 balance of the Benefit Amount from August, the Beneficiary must submit a claim for another Premium for insurance coverage in effect in August. See Q&A 4 for types of insurance premiums reimbursable from the Plan.

7. What happens if I pay my Premium annually or quarterly, or some other schedule that is not monthly? Can I get reimbursement for the Premium in each month of the coverage?

Yes. If you submit a claim for reimbursement of a Premium payment that pays for multiple months of coverage, the Trust Office will reimburse you for that Premium cost in each month of coverage. For example, a quarterly Premium payment of $900 would be reimbursed over the three months of coverage at $300 per month, provided your total claimed Premiums do not exceed the Benefit Amount. Likewise, an annual premium of

$2400 would be reimbursed over the 12 months of coverage at $200 per month. You cannot receive more than the monthly Benefit Amount of $425 even if your actual Premium cost for the month is more than $425.

8. What will the monthly benefit be for my spouse and children in the event of my death?
Starting the month after the death of the Eligible Retiree or the month after the otherwise Eligible Retiree would have attained age 58 (had he/she died prior to age 58), a Surviving Spouse receives the same monthly Benefit Amount as an Eligible Retiree. Effective July 1, 2024, the monthly Benefit Amount is $425. If there is no Surviving Spouse, the surviving Children (if any), will receive a monthly benefit, starting the month after the Eligible Retiree's death. The monthly benefit for the surviving Children will be 50% of the Benefit Amount, to be split amongst the surviving Children based upon the claims submitted each month.

A Surviving Spouse is the lawful spouse of an Eligible Retiree, who has been the spouse of the Eligible Retiree for at least twelve (12) months on the date of death of the Eligible Retiree. A Surviving Child or Child is the natural child, legally adopted child, or stepchild of the Eligible Retiree, who is under age 26. Child or Surviving Child also includes a child of the Eligible Retiree of any age who is totally disabled as determined by the Social Security Administration. The Surviving Spouse and Surviving Children of an Employee who has attained all eligibility requirements in Q&A 2 above, but dies before attaining the eligibility age of 58, are still eligible for survivor benefits, subject to the benefit commencement requirements for survivor benefits.

Note that the Trust grants the same rights and benefits to same-sex spouses as it does to opposite sex spouses. If you have entered into a same-sex marriage, please notify the Trust Office.

9. Does the Plan offer benefits for my Domestic Partner in the event of my death?
Yes, however, the monthly benefits paid for Domestic Partner and Surviving Domestic Partner Premium reimbursements are limited by federal law. Federal tax law provides that the aggregate amount of benefits paid to all Domestic Partners annually shall not exceed 3% of the total benefits paid annually under the Plan, which the Plan will calculate within 30 calendar days after the end of each Plan year. See Plan Section 3.2(c).

To qualify as a Domestic Partner, the individual must meet all of the following requirements, and the Eligible Retiree and Domestic Partner must sign an affidavit to that effect.

- 18 years of age or older;
- Share the same permanent residence as the Eligible Retiree and intend to do so indefinitely;
- Sole domestic partner of the Eligible Retiree;

- Not married to, or in a domestic partnership with, or legally separated from, anyone else;

- Not related by blood to the Eligible Retiree closer than would be a bar to marriage in the State of California; and

- Jointly responsible for the Eligible Retiree's basic living expenses such as food, shelter and other necessities of life.

Generally, the monthly benefit for a Surviving Domestic Partner will be the same as for a Surviving Spouse, subject to the federal law limit described above. If the annul 3% cap on aggregate Domestic Partner benefits is exceeded, the Plan will recoup the excess benefit payments from future benefits or via direct request for repayment, according to rules adopted by the Trustees. The Plan will also deduct the recouped (or repaid) amount from the taxable income reported on Form 1099. (See the next paragraph regarding Form 1099).

The IRS does not allow tax-free benefits to Domestic Partners. Therefore, if you claim reimbursement for a Premium for your Domestic Partner, the amount of the Premium reimbursement covering the Domestic Partner will be taxable income to the Beneficiary, and the Trust Office will send you a Form 1099 at the end of the tax year. If you want to avoid taxable income from benefit payments, you can claim only the Premiums for the Eligible Retiree, and Beneficiaries other than your Domestic Partner.

Costs and Taxes Deducted from Domestic Partner Benefit Payments. The process of implementing taxation of benefits requires the Trust Office to perform multiple administrative steps, including calculating the taxable income and preparing a Form 1099. The Trust may also have to pay employment taxes on the taxable income reported for Domestic Partner benefits. Therefore, the Trust may charge these administrative costs and additional taxes to the Domestic Partner who is receiving the benefit payment. The Trust Office may deduct these costs and taxes from the benefit amount payable to the Domestic Partner.

10. How do I submit my claims for benefits? What are the appeal procedures for denied claims?

To present a claim for benefits under this Plan, the Beneficiary must submit a written claim form, along with supporting documentation, to:

Santa Monica City Employees Coalition Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor, Los Angeles, CA 90017
E-mail: santamonicacity@bpabenefits.com
Phone: (800) 828-0233

Claim forms are available from the Trust Office. Claims are generally paid on approximately the 7th of each month to reimburse Premiums paid for the prior month's

coverage. For example, the February 7th claim payment reimburses January Premiums and the January 7th claim payment reimburses December Premiums.

Provided you submit the claim form and required supporting documentation by the deadlines explained in Q&A 11, you will receive recurring Premium reimbursements each month. If you do not submit the required documentation to support your claim, the Trust Office will suspend your benefit payments until the Trust Office receives proper documentation of your Premiums. If your Premiums change, you are required to notify the Trust Office immediately and submit a new claim form and supporting documentation for the new Premiums.

Note that in the event the Trust Office overpays you for benefits, the Plan has the right to deduct the overpaid amount from subsequent benefit payments until the Plan has recouped the overpaid amount, or the Plan may seek repayment of the overpaid amount from you directly to the Plan. The Plan also has the right to recoup or seek repayment of benefits paid without timely supporting documentation.

11. What are the deadlines to provide supporting documentation of Premiums?

Effective for Premiums for 2025 insurance coverage, there are two deadlines for submitting claims and providing supporting documentation of most recurring Premiums, i.e., Premiums that you pay monthly. However, you can submit all of these documents in one transaction by January 31, 2026, and following years (e.g., January 2026 Premium information and proof of 11 monthly Premium payments for 2025 insurance coverage are both due by January 31, 2026). You can also submit your proof of monthly payment of Premium each month as you pay it, or on some other schedule that is convenient for you, as long as the Trust Office receives all 11 months of proof by January 31 of the following year. See exceptions below for Medicare Premiums and Premiums paid on another schedule.

- January 31 of Year of Insurance Coverage: In order to initiate monthly reimbursement of Premiums for the Plan year, you must submit the following documents by January 31st of the year of the insurance coverage (e.g., by January 31, 2026, for January 2026 insurance coverage):
  - Completed and signed claim form.
  - Third-party documentation of your insurance coverage with dates of coverage, type of coverage, and amount of Premium.
  - Proof of payment of January Premium.

- January 31 of the Year Following Insurance Coverage: Effective for Premiums for 2025 insurance coverage, to provide full supporting documentation of the Premiums reimbursed to you throughout the year, you must submit proof of your payment of each of the remaining 11 monthly Premiums by January 31st of the following year (e.g., by January 31, 2026, for monthly Premiums paid for 2025

insurance coverage).[3] If Premiums are paid quarterly or semi-annually, the Trust Office must receive proof of payment of each Premium that provides coverage for the remainder of the year, i.e., quarterly would require proof of 4 payments and semi-annually would require proof of 2 payments. See discussion below on annual Premiums. If you do not provide sufficient proof of payment for each Premium reimbursed, your future benefit payments will be suspended until such documentation is provided, and the Plan has the right to recoup from future benefit payments or seek repayment of any Premiums that are not sufficiently substantiated by supporting documentation in a timely manner.

- Exceptions:
  - *Medicare Premiums.* If Medicare premiums are paid by deduction from Social Security or Railroad Retirement payments, the Beneficiary only needs to submit the items required for the January 31 deadline in order to receive monthly Premium reimbursements. The annual Social Security Administration statement or Railroad Retirement Board statement showing deductions for Medicare premiums is sufficient proof of Premium payment for all months of the year.

  - *Premiums Paid Annually or Other Than Monthly (e.g., Quarterly or Semi-Annual).* All Beneficiaries need to submit the items required to substantiate the Premium at the beginning of the year, i.e., completed and signed claim form, third-party documentation of your insurance coverage with dates of coverage, type of coverage, and amount of Premium, and proof of payment of the first Premium. If the Premium is paid annually, then reimbursement requires only one claim submission and one proof of payment of the annual Premium. If the Premium is paid quarterly, then four proofs of payment are required by January 31 of the following year. Semi-annual Premium payment would require submission of two proofs of payment, etc. See Q&A 7 on reimbursement of annual or quarterly Premium expense.

12. What documentation is sufficient for proof of Premium payment?

The following documents are sufficient to prove that the Beneficiary paid the Premium payment for substantiation of claims, as required by Q&A 11 above:

- Canceled check drawn to the name of the medical insurance provider;
- Credit card or bank statement showing proof of payment to the insurance carrier;
- Receipt for payment from the medical insurance provider;

[3] This documentation requirement is effective starting with 2025 Premiums for insurance coverage, and the first deadline will be January 31, 2026.

- Written confirmation of electronic payment to the insurance provider;
- Annual Social Security Administration or Railroad Retirement Board statement showing Medicare premium payment deduction;
- Pension plan statement showing premium payment deduction; or
- Other third-party documentation approved by the Trustees.

13. Who has the right to submit claims?

Only one Beneficiary has the right to submit claims, and the priority for that right is as follows: The Eligible Retiree has the right to submit claims during his or her lifetime, unless the Eligible Retiree delegates that right to his or her spouse in writing. The Eligible Retiree can submit claims for Premiums of his or her legal spouse[4] or Domestic Partner, and Children, but there is only one monthly Benefit Amount for reimbursement of all Beneficiaries' claims. After the death of the Eligible Retiree, the Surviving Spouse or Surviving Domestic Partner has the right to submit claims, unless the Surviving Spouse is under age 58 and not eligible. If the Surviving Spouse is under age 58 or there is no Surviving Spouse, then the Surviving Children have the right to submit claims.

In the circumstance that the Eligible Retiree delegates the authority to submit claims to his or her spouse or the Surviving Spouse delegates the authority to submit claims to his or her child, the family member would help submit the claims to the Trust Office and sign the claims form on the Beneficiary's behalf, but the Trust Office will still pay all benefit payments to the Beneficiary. You can contact the Trust Office to get a form for Delegation of Authority to Submit Claims. Please note that the signatures on the form must be notarized. The delegation can be revoked at any time by a written communication to the Trust Office.

14. Which Beneficiary's Premiums are reimbursed first on a claim?

The Plan sets the priority for payment of claims amongst Beneficiaries within a family. Each Eligible Retiree has only one Benefit Amount (currently $425 per month) for reimbursement of Premiums for all Beneficiaries in the Eligible Retiree's family. The Plan reimburses claims and Premiums in the following order to avoid conflicting claims for the same Benefit Amount and to minimize taxable benefits:

1) Eligible Retiree or Surviving Spouse
2) Legal Spouse of Eligible Retiree
3) Children or Surviving Children of Eligible Retiree
4) Domestic Partner or Surviving Domestic Partner of Eligible Retiree

[4] Spouse includes any lawful spouse. Note that the Trust grants the same rights and benefits to same-sex spouses as it grants to opposite-sex spouses. Please keep the Trust Office notified of your marital status and your current spouse.

Almost all reimbursements from this Plan for Premium[5] expenses will be non-taxable to you. However, federal law prohibits nontaxable benefit payments to Domestic Partners because the IRS does not consider Domestic Partners to be tax dependents. So, benefit payments from the Plan to reimburse Premiums of Domestic Partners are taxable to the Eligible Retiree or Surviving Domestic Partner. This is the reason that Domestic Partner and Surviving Domestic Partner Premiums are reimbursed last from the monthly Benefit Amount. If there are non-taxable benefits that can be paid from the monthly Benefit Amount first, then the portion of the benefits that have to be taxed is reduced by following the above-listed priority. You can request that your claims be paid in a different manner by contacting the Trust Office; however, you may incur additional income taxes on the benefit payments.

The following examples are provided for your consideration in submitting claims:

1) If an Eligible Retiree and his/her Domestic Partner have Premium expenses of $250 each, the Eligible Retiree will receive a benefit payment equal to the full $425 Benefit Amount. That benefit payment will consist of a $250 nontaxable reimbursement of the Eligible Retiree's premiums in full and a $175 taxable reimbursement of the Domestic Partner's premiums in part.

2) Similarly, if a Surviving Domestic Partner submits a claim for reimbursement of $250 in Premiums for him/herself and $200 in Premiums for a Surviving Child of the deceased Eligible Retiree, the Surviving Domestic Partner will receive a benefit payment equal to the full $425 Benefit Amount. That benefit payment will consist of a $200 nontaxable reimbursement of the Surviving Child's Premiums in full and a $225 taxable reimbursement of the Surviving Domestic Partner's Premiums in part.

3) In addition, you can minimize your taxable benefits by submitting claims on behalf of the Eligible Retiree and Children that equal or exceed the Benefit Amount. If the Eligible Retiree submits a claim for reimbursement of Premiums for him/herself that equals or exceeds the Benefit Amount, then the full benefit payment to the Eligible Retiree will be for reimbursement of these Premiums and will be nontaxable. If only Domestic Partner or Surviving Domestic Partner Premiums are submitted for reimbursement, then the full benefit payment will be taxable.

15. How do I appeal a claim denial or other adverse determination of the Trust Office?
To appeal a claim denial or eligibility determination or seek clarification or enforcement of rights under the Plan, a Beneficiary must submit a written request to the Trust Office

[5] "Premium" is defined in the Plan as an insurance premium payment to a health plan (medical, dental, vision, or long-term care) that is tax-deductible as medical care under Code Section 213(d), or as long-term care insurance premiums under Code Section 7702B, and provides for coverage of a Beneficiary while the Beneficiary is eligible for benefits under the Plan.

within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. An appeal is considered submitted and filed with the Trust Office on the date that it is received/date stamped at the Trust Office. The Board of Trustees will hold a hearing on the appeal, and the Beneficiary will be entitled to present his or her position and any evidence in support of his or her appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

The Trustees have broad discretionary authority to determine eligibility for benefits, to grant or deny claims for benefits, to interpret and apply the provisions of this Plan, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision is binding and conclusive.

16. Is there a time limit for filing a lawsuit against the Trust for benefit payments, etc.?

Yes, there is a limitation period for filing a lawsuit against the Trust. A Beneficiary has the right to bring action in federal court pursuant to ERISA Section 502(a) no later than **one year** after the exhaustion of administrative remedies (i.e., the appeal process discussed in Q&A 15 above), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court. The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits, and the Trustees anticipate that an action brought in federal court challenging the Trustees' exercise of their discretionary authority will be subject to a deferential standard of review.

17. Can I assign my rights and benefits under the Plan to a medical provider or other entity?

No, the Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Premiums you will submit to the Plan for payment. The Plan will not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. Details of this restriction are in Plan Section 3.6. (There is an exception for incompetent Beneficiaries with a court appointed representative. See Plan Section 3.5(g)).

18. Who pays the costs of evaluating and implementing a Qualified Domestic Relations Order ("QDRO") or Qualified Medical Child Support Order ("QMCSO")?

The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse as a deduction applied to the benefit payments. The costs include, but are not limited to, the following: administrative costs for dividing the Benefit Amount and setting up benefits for the ex-spouse; legal fees for evaluation of the court order and to advise the Trust Office on implementation of a QDRO or QMCSO; and actuarial fees to calculate the benefit level of the ex-spouse. The costs deducted from benefit payments of the Eligible Retiree and ex-spouse may vary from one divorce situation to another and may be spread amongst several months of benefit payments.

19. What is the Plan Year?

The Plan year runs from January 1 to December 31.

20. What should I do if I change my address, spouse, or children?

It is the Participant's responsibility to notify the Trust Office of any change in mailing address, spouse or children. Note that it is important to keep this type of information updated with the Trust Office so that notices related to the Plan and benefit payments may be sent to you and/or your Beneficiaries. Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan. Please update the Trust Office with any changes to your address or Beneficiaries by contacting the following:

Santa Monica City Employees Coalition Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor, Los Angeles, CA 90017
E-mail: santamonicacity@bpabenefits.com
Phone: (800) 828-0233

21. What are the circumstances that may result in ineligibility or denial of benefits; or amendment or termination of the Plan?

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include failure by the employer to make required contributions, failure to properly submit proof of qualified Premiums, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note the following events will cause termination of benefits:

- An Eligible Retiree's benefits under this Plan will terminate upon his/her death.
- An Eligible Retiree's benefits under this Plan will be suspended upon return to employment with the City; provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with the City.
- A Surviving Spouse's benefit under the Plan will terminate upon the death of the Surviving Spouse.

- A Surviving Child's benefits under this Plan will terminate upon the loss of Child status under the Plan.
- Benefit coverage and Benefit Amounts may be modified or terminated pursuant to Section 6 of the Plan and such changes may apply to some or all current and/or future Beneficiaries.
- Article XIII of the Trust Agreement addresses Plan termination. It requires that assets of the Plan that remain after payment of expenses associated with termination be allocated and distributed to the Plan Beneficiaries in accordance with Code Section 501(c)(9).

22. What are the names, email addresses and street address of the Trustees?

You can reach the Trustees via mail or serve process on the Trustees through the following Trust Office address:

Santa Monica City Employees Coalition Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017

The Trustee email addresses are as follows:

Carl Olson, Board Chairperson **CPO4AJO@gmail.com**	Supervisory Team Associates
Hakhamanesh Mortezaie, Board Secretary **Hakhamanesh.mortezaie@smgov.net**	Rent Control Board
Lyn Beckett Cacciatore **Lyn.cacciatore@gmail.com**	Public Attorneys' Union
Araceli Esparza **Celi.esparza@gmail.com**	Management Team Associates
Stephen Jones **socalkamaaina@yahoo.com**	Municipal Employees Association
Yvette Pierre **Yvette.Pierre@santamonica.gov**	Administrative Team Associates
Mary Ann Yurkonis **mayurkonis@roadrunner.com**	Executive Pay Plan
Carlos Rubio **crubio@teamsters911.com**	International Brotherhood of Teamsters

Bradley Michaud **Bradley.michaud@smgov.net**	Public Attorneys' Legal Support Staff Union
Vacant	SMART-TD

23. Is there any other information about this Plan I should know?

A. The name of the Plan and Trust.
This Plan is known as the "Santa Monica City Employees Coalition Benefit Trust Premium Reimbursement Plan," amended and restated effective August 1, 2024, and as amended thereafter (the "Plan"). The Plan is governed by the "Trust Agreement Governing the Santa Monica City Employees Coalition Benefit Trust," effective July 1, 2001, and as amended thereafter (the "Trust Agreement"). For a copy of the Plan or the Trust Agreement, please contact the Trust Office.

B. The name and address of the employee organization that established this Plan.
This Plan was established by the Coalition of Santa Monica City Employees, P.O. Box 3007, Santa Monica, CA 90408; email: coalitionsmce@verizon.net or contact@csmce.org

C. The identification numbers of the Trust and Plan.
The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 30-6001608. The Plan number is 501.

D. The type of plan.
The Plan is a welfare benefit plan providing health insurance premium reimbursement benefits to retirees. Beneficiaries may check with the Trust Office to determine if a particular insurance premium is a permissible reimbursement under the Plan.

E. The type of administration/Trust Office.
The Board of Trustees of the Santa Monica City Employees Coalition Benefit Trust administers the Plan. The contact information for the Trust Office is:

Santa Monica City Employees Coalition Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-mail: **santamonicacity@bpabenefits.com**
Phone: (800) 828-0223

F. The identify of the Plan Administrator.

The Plan Administrator (fiduciary) is the Board of Trustees of the Santa Monica City Employees Coalition Benefit Trust. They may also be contacted in care of the Trust Office.

G. The existence of a bargaining agreement that addresses this Plan and Trust.

The Plan is maintained pursuant to the "Memorandum of Understanding Setting the Terms and Conditions of Medical Insurance Coverage Between City of Santa Monica and Management Team Associates, Supervisory Team Associates, Administrative Team Associates, Municipal Employees Association, International Brotherhood of Teamsters Local 911, Public Attorney's Union, Public Attorney's Legal Support Staff Union, United Transportation Union (Local 1785)-SMART, Executive Pay Plan Participants and certain unrepresented classifications," effective January 1, 2015, through December 31, 2018, and as extended, amended or replaced thereafter ("MOU"), and the "Side Letter of Agreement Setting the Terms and Conditions of Medical Insurance," between the same parties, effective through December 31, 2023.

H. Information regarding the Family Medical Leave Act.

Please contact the Trust Office and/or your Employer if you would like to learn more about the right to self-pay contributions during FMLA leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

I. Uniformed Services Employment and Reemployment Rights Act (USERRA).

If your contributions to this Plan cease due to a leave of absence for active duty military service, you have the right under USERRA to self-pay contributions for up to 24 months of that period of leave. If you would like to take advantage of your rights under USERRA, contact the Trust Office for details. Regardless of whether or not you elect to self-pay contributions under USERRA, the Plan will preserve all Active Service that you earned prior to your period of leave and that Active Service will be added to any future Active Service that you earn after return to City employment following your leave of absence.

J. Information regarding COBRA.

The COBRA General Notice is provided at the back of this Summary Plan Description. If you have not received or would like to request a copy of the COBRA General Notice, please contact the Trust Office.

A Qualified Beneficiary must provide written notice of the following Qualifying Event(s) to the Trust Office by either first class mail or facsimile (fax):

- Divorce or Legal Separation;
- Loss of Child Status;

- Notice of a Second Qualifying Event
- Disability;
- Change of Disability Status

Please see Section 4 of the COBRA General Notice for the notice deadlines related to specific Qualifying Events.

If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions.

K. Qualified Domestic Relations Order (QDRO)

The parties to a divorce proceeding can divide the monthly benefits earned during the marital period, but that division can only be implemented pursuant to a valid QDRO, as determined by the Plan. The Plan reserves the right to determine whether a domestic relations order is a QDRO. The Trustees have adopted procedures and a model QDRO for this purpose.

Upon notice of the intent to secure a QDRO, the Plan will segregate 50% of the community property benefits that the Employee earned during the marriage, and set those funds aside for potential future payment to the Alternate Payee (Employee's or Eligible Retiree's ex-spouse) after the QDRO is approved. The Plan will segregate the Alternate Payee's share of monthly benefits for no more than 18 months from the date that this segregation begins. If the Alternate Payee obtains a QDRO prior to the end of the 18-month period, the Plan will pay the Alternate Payee his or her share of the segregated benefits in accordance with the Plan's rules. If the Alternate Payee fails to obtain a QDRO within this 18-month period, the Plan will provide the segregated benefits to the Employee or Eligible Retiree in accordance with the Plan's rules and will stop segregating future benefits.

A former spouse of an Employee or Eligible Retiree under a QDRO, known as an Alternate Payee, may commence receiving his or her portion of the monthly Benefit Amount at a time specified in the QDRO, but no earlier than the earliest date that the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the Participating Employer on such date. An Alternate Payee's monthly benefits will not be suspended if the Employee returns to employment with a Participating Employer. An Alternate Payee's monthly benefits will terminate on the first of the month following the Alternate Payee's death.

The Surviving Children of the marriage of the Eligible Retiree and Alternate Payee may begin receiving benefits starting the month after the death of the Alternate Payee and such Surviving Children's benefits will terminate on the date the last Surviving Child no longer meets the definition of Child or the date of death of the last Surviving Child.

Beneficiaries can obtain from the Trust Office, without charge, a copy of the procedures governing the determination of whether a Domestic Relations Order is qualified. The Trust may assess a fee on the Employee/Eligible Retiree and Alternate Payee for the review process. (The same applies for Medical Child Support Orders.)

L. The source of contributions to the Trust.

Contributions to this Plan must be non-elective, and are made by the City of Santa Monica, based on the Memorandum of Understanding with the Coalition of Participating Associations. Further, under certain circumstances, Beneficiaries may make self-payment contributions, as provided by COBRA or other federal law.

M. The method that is used for the accumulation of assets.

Contributions are received by and held in trust by the Trust and are invested with the assistance of a professional investment manager, utilizing investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 (ERISA) requirements.

N. The procedures governing Qualified Medical Child Support Order Determinations (QMCSO).

Beneficiaries can obtain, without charge, a copy of such procedures from the Trust Office.

O. The name and address of the agent for service of process.

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Trustee or the Trust Office at the address listed in Section 14E above.

P. Statement of Legal Rights.

- Rights of Plan Participants. Beneficiaries of the Santa Monica City Employees Coalition Benefit Trust are entitled to certain rights and protection under the federal Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

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

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual report upon request. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.

If there is a cessation of contributions to the Plan as a result of a COBRA qualifying event, you or your family members may have to continue such contributions by self-payment. Review the COBRA General Notice and the Plan, Sections 2.2(b) and 2.2(c) for rules governing your COBRA continuation coverage rights.

If you have creditable coverage from another plan, you should be provided a certificate of creditable coverage, free of charge, from your Group Health Plan or health insurance issuer in certain circumstances when you lose coverage under the Plan.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of this employee welfare benefit plan.

  These persons who operate your Plan and Trust are called "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan Beneficiaries and they must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Trust. No one, including an employer, may fire or otherwise discriminate against members to prevent them from obtaining a welfare benefit or exercising their rights under ERISA.

- Enforce Your Rights. If a claim for a welfare benefit is denied or ignored, in whole or in part, Beneficiaries have a right to know why this was done, 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 that can be taken to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses 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 a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim to be frivolous.

- Assistance with Your Questions. If you have any questions about this 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 at (866) 444-EBSA (3272).

- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1966 (HIPAA) requires special precautions be taken by health benefit plans to protect the privacy of "protected health information." In the course of providing benefits to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. The HIPAA Notice of Privacy Practices is attached to this document. If you would like more details about your privacy rights, please contact the Trust Office.

COBRA GENERAL NOTICE
of the
SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST

<< IMPORTANT COBRA INFORMATION >>
THIS COBRA INFORMATION WILL INFORM YOU OF YOUR RIGHTS AND OBLIGATIONS UNDER COBRA. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

Under this type of health plan, i.e., a retiree premium reimbursement plan, COBRA benefits mean the right to continue contributions to the Trust, in order to obtain certain Plan benefits after retirement. This Plan gives the Employee (or family member) the right to self-pay contributions into the Trust, which were formerly being paid pursuant to a collective bargaining agreement or other special agreement while the Employee was working. The Employee, generally, has the right to continue self-payments for 18 months, and the family member, generally for 36 months.

For employees hired prior to January 1, 2009, this Plan requires five (5) years of Active Service[1] to be eligible for benefits (or 10 years of Active Service for employees hired after December 31, 2008). Therefore, this COBRA self-pay option is only worthwhile to the Employee or family member if the Employee experienced a Qualifying Event within 18 months (or 36 months for the family member) of earning the five (5) years (or 10 years, if applicable) of Active Service. Of course, the other Eligibility Rules required by the Plan must have been met as well. If you have questions regarding the eligibility requirements under the Plan, or are in doubt about the application of COBRA under this Plan, please contact the Trust Office.

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of your health care premium costs after retirement,[2] rather than health benefits immediately following active employment. That is, this Plan is for retiree health benefits, not benefits soon after termination of active employment.

1. **COBRA, Generally.** You are a participant in the 'Premium Reimbursement Plan for Retirees" (hereafter the "Plan") of the Santa Monica City Employees Coalition Benefit Trust (hereafter the "Trust"), which provides reimbursement towards certain health care premium costs, as defined in the Plan, after retirement. Continued participation in any

[1] Generally, Active Service is accrued during full-time employment with a participating employer and/or during the period of COBRA self-payments. See Section 2.2 of the Plan for details.

[2] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay coverage to terminated Employees until retirement. The Plan accepts contributions during active employment, which are held by the Trust and will be used by Employees to purchase health coverage after retirement. In the event of the Employee's death, payments to the Surviving Spouse will commence the month after the Employee would have attained age 58.

health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[3]

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUITONS UNDER COBRA MAY BEOCME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

2. **COBRA Coverage Means the Right to Self-Pay Continued Contributions to Plan for Benefits After Retirement.**

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Trust by self-payment, when contributions to the Trust would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying Event, the Plan must offer each person who is a "Qualified Beneficiary" the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a collective bargaining agreement or special agreement. By offering a Qualified Beneficiary this right, generally the Plan is offering that individual the ability to increase their benefits from the Plan in the following way:

> The ability to meet eligibility requirements to receive a lifetime[4] monthly reimbursement benefit from the Plan after retirement, which he/she may not otherwise have bene able to meet (see **Section 2(B)** below).

You, your spouse, and your dependent children could become Qualified Beneficiaries if contributions to the Trust on behalf of the covered employee cease due to a Qualifying Event.

B. Plan Eligibility Requirements. To be eligible to receive these premium reimbursement benefits after retirement, this Plan requires that an Employee hired prior to January 1, 2009 earn five (5) years of Active Service (or 10 years if the Employee was hired after December 31, 2008). Active Service is defined in Section 2.2 of the Plan. Therefore, making COBRA self-payments could make you eligible, depending on how many years of Active Service you have earned at the time of the Qualifying Event. It is important for you to determine whether making these additional contributions makes sense in your particular situation If you choose to continue making contributions to this Plan, the number of your self-pay

[3] Public Law 99-272, Title X

[4] The Plan is currently written to provide benefits for most Retirees until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of the Plan.

contributions is limited to the number allowed by COBRA, as stated in **Section 7** below.

C. Consequences of Non-Election. If you do not choose to continue contributing to this Plan and you have not earned five (5) years of Active Service (or 10 years, if applicable), you will forfeit any benefits, contributions made, and Active Service earned under this Plan.

D. Surviving spouses and children. Surviving spouses and children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in **Section 5** below for details.

3. **Qualifying Events and Qualified Beneficiaries**.

A. Employee as a Qualified Beneficiary. If you are an **Employee**, you will become a Qualified Beneficiary and have the right to self-pay contributions for yourself (and your beneficiaries), if contribution to the Trust on your behalf cease due to any of the following "Qualifying Events:"

i) Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or

ii) Reduction of Work Hours. Your hours of employment are reduced or you are on unpaid leave.

Either of these Qualifying Events generally gives you the right to continue self-payment of contributions to this Plan.

B. Spouse as Qualified Beneficiary. If you are the **spouse of an Employee** covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Trust on your spouse's behalf cease due to any of the following "Qualifying Events,"[5] and provided that the Employee does not elect to self-pay contributions under COBRA:*

i) Spouse's Death. The death of the Employee spouse; or

ii) Termination of Spouse's Employment. A termination of the Employee spouse's employment (for reasons other than gross misconduct); or

iii) Reduction of Spouse's Work Hours. A reduction in the Employee spouse's hours of employment, provided that your spouse does not elect to self-pay contributions under COBRA; or

[5] Applicable to typical health plans, but not applicable to this Plan are the following Qualifying Events: 1) your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); and 2) you become divorced ore legally separated from your spouse.

iv) Divorce. If the Employee and spouse divorce during contributions or during benefit payments, a QDRO will provide more rights to ongoing and future benefit payments than COBRA, but this is a Qualifying Event for COBRA.

*NOTE:

Only one member of a family may make self-payment contributions in this type of health plan. If there are multiple Qualified Beneficiaries, for example a former employee and a spouse, you should confer together and decide whether electing to make COBRA self-pay contributions makes sense in your case, and which of you will make the election. It is important to note that due to the nature of this type of Plan, you do not each have independent rights to elect self-payment. This means that only one Qualified Beneficiary can self-pay.

C. Child as Qualified Beneficiary. If you are a **Child of an Employee** covered by this Plan, you may become a Qualified Beneficiary and have rights to self-pay contribution to this Plan if contributions to the Trust on your parent's behalf cease due to any of the following Qualifying Events,[6] and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

i) Death of Parent. The death of the covered parent; or

ii) Termination of Parent's Employment. The termination of the covered parent's employment (for reasons other than gross misconduct); or

iii) Reduction of Parent's Work Hours. A reduction in the parent's hours of employment, whether neither the employee parent nor spouse elect to self-pay contributions under COBRA.

iv) Loss of Child Status. If a Child attains age 26 and loses current reimbursement benefits under the Plan because he/she no longer qualifies as a Child under the Plan.

*See "Note" under **Section 3(B)** above.

4. **Notification of Qualifying Event**

A. Employer's Notification Responsibility. The Plan will offer the COBRA option to self-pay contributions to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** has the obligation to notify the Plan Administrator of

[6] Some health plans recognize the following qualifying Events; 1) the parent becomes entitled to Medicare benefits (under Part A, Part B, or both); 2) the parents become divorced or legally separations, and 3) the child loses dependent child status under the Plan. However, due to the structure of this Plan, these are not recognized Qualifying Events.

the Qualifying Event. However, we encourage the employee to also give notice to the Plan, in case the employer fails to do so.

B. Qualified Beneficiary's Notification Responsibility. Under COBRA, the **Employee or a family member has the responsibility** to provide written notice, within the time limits described in **Section4(C)** below, to the Trust Office of the occurrence of any of the following Qualifying Events:

i) Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan; or

ii) Divorce of the Employee and spouse.

iii) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to self-pay contributions under COBRA for a maximum period of eighteen (18) months (or twenty-nine (29) months in the case of a disability, as described in **Section 6** below); or

ii) A Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or

iii) A Qualified Beneficiary, who was determined as disabled is subsequently determined by the Social Security Administration as no longer disabled.

C. Timing Requirements for Qualified Beneficiaries to Notify the Trust Office of Qualifying Events.

i) Qualifying Events Other Than Disability. The period of time for providing notice to the Trust Office for the occurrence of a second Qualifying Event is **sixty (60) days after** the latest of:

a) *Qualifying Event*. The date that the Qualifying Event occurs; or

b) *Contributions to the Trust Cease*. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

c) *The Date you Receive Notice*. The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

ii) Qualifying Event of Disability. The period of time for providing notice to the Trust Office of a disability determination is **sixty (60) days after** the latest of the following events (but no later than the end of the first eighteen (18) month period of self-payment contributions):

a) *Determination by Social Security Administration*. The date of the disability determination by the Social Security Administration.

b) *Disability*. The date that the disability occurs;

c) *Contributions to the Trust Cease*. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

d) *The Date you Receive Notice*. The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

iii) Change of Disability Status. The period of time for providing notice to the Trust Office of a change in disability is **thirty (30) days after** the latest of:

a) *Determination by Social Security Administration*. The date the Social Security Administration determines that you are no longer disabled; or

b) *Notice of Responsibility and Procedure*. The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice to the Trust Office (see **Section 5** below).

5. **Procedures for Notifying Plan of Qualifying Event**. Subject to the time limits in **Section 4(C)** above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s) described in **Section 4(B)** above to the Trust Office by either first class mail or facsimile (fax). The contact information for the Trust Office is as follows:

Santa Monica City Employees Coalition Benefit Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Email: **santamonicacity@bpabenefits.com**

The notice of the Qualifying Event should include:

A. Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

B. Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

C. Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

When the Trust is notified that one of these Qualifying Events has occurred, it will in turn notify you about details concerning your election to continue your contributions to the Trust for the right to receive future benefits.

6. **Maximum Length of COBRA Payments**. Once you have elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within 45 days of your election. Subsequent periodic payments must be made on a monthly basis and are due on the first of each month, but no later than 30 days following the first of the month. **You will not receive monthly reminders that payment is due**.

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment contributions.

i) 18 month period. When the Qualifying Event is a termination of employment or reduction in hours of employment, the law requires that you be given the opportunity to self-pay contributions for eighteen (18) months.

ii) 36 month period. When the Qualifying Event is death of the covered employee, divorce or loss of Child status, the COBRA law requires that you be given the opportunity to continue to make contributions to the Trust by self-payment for thirty-six (36) months (three years).

B. Second Qualifying Event Extension (18 month extension of the initial 18 month period). If a second Qualifying Event, other than termination of employment, occurs during the eighteen (18) month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to eighteen (18) months of self-payment contributions, for a maximum of thirty-six (36) months. See **Sections 4 and 5** relating to notification requirements and procedure in the case of a second Qualifying Event.

C. Disability Extension (11 month extension of the initial 18 month period). If a Qualified Beneficiary under the Plan is determined by the Social Security Administration to be disabled, the Plan beneficiaries may be eligible to self-pay for an additional eleven (11) months, for a total of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of the COBRA self-payment contributions and must last at least until the end of the 18-month period of self-payment contributions. See **Sections 4 and 5** relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional eleven (11) months may be approximately 50% higher than the amount of the first eighteen (18) months if the self-payment contributions include a disabled beneficiary and the extension of period for self-payment contributions would not be available in the absence of a disability.

7. **Termination of COBRA Payments**. The COBRA law provides that your right to continue COBRA payments may be terminated prior to the full self-payment period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

   A. The Trust no longer maintains the Plan; or

   B. Your employer no longer contributes to the Plan on behalf of employees; or

   C. The monthly self-pay contribution to the Trust under COBRA is not paid timely; or

   D. There has been a final determination that you are no longer disabled if you qualified to make an extra eleven (11) months of self-pay contributions based on disability.

   You do not have to show that you are insurable to choose continued participation.

8. **Refund of Contributions Erroneously Paid**. Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Plan Administrator and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to self-pay contributions. Any Active Service granted based on an erroneous contribution will be rescinded.

9. **Questions about COBRA**. If you have any questions about the Plan or your COBRA continuation self-payment rights, you should contact the Trust Office at the address and/or phone number appearing below.

Santa Monica City Employees Coalition Benefit Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: (213) 406-2360
Toll Free: (800) 828-0223
Email: **santamonicacity@bpabenefits.com**

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBS) in your area or visit the EBSA website at **www.dol.gov/ebsa**

10. **Address Changes**. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in marital status or address of yourself and family members. Send all address changes to the Trust Office address stated in **Section 9** above. You should also keep a copy for your records of any notices you send to the Plan Administrator.

SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST

NOTICE OF PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION

Introduction. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to information, called protected health information, that identifies a particular individual and relates to the past, present, or future physical or medical condition of the individual, provision of health care to the individual, or payment for the provision of health care to the individual. The Santa Monica City Employees Coalition Benefit Trust is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the manner in which it may be used or disclosed.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **Our Duties Concerning Protected Health Information**. As the administrative agent for the Board of Trustees of the Trust, we are required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We are also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulation about which you can obtain further information by contacting the Privacy Contact Person identified in Section VII of this Notice.

If any applicable state or federal law imposes limitations upon uses and disclosures of protected health information that are more stringent than the limitations imposed under the Privacy Rule, we are required to adhere to those more stringent limitations.

II. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**. Except with respect to uses or disclosures that require an authorization as described in Section IV of this Notice, we may use or disclose protected health information for treatment, payment, or health care operations as set forth in Paragraphs II(A) – II(D) below, without obtaining your consent. We may elect to obtain your consent to use or disclose protected health information for such purposes, although we are not required to do so. Moreover, such consent shall not be effective to permit a use or disclosure of protected health information that requires an authorization as described in Section IV of this Notice.

A. For our payment of premium reimbursement claims. Payment includes but is not limited to actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to premium reimbursement.

B. For the payment activities of another covered entity or health care provider to whom we disclose the information. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. To another covered entity for health care fraud and abuse detection or compliance or health care operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains and information disclosed pertains to that relationship.

D. To disclose protected health information to the Board of Trustees of the Trust, as the plan fiduciary, as necessary for Trust administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

III. **Other Uses and Disclosures Permitted or Required Without Authorization**. We may, by complying with the requirements specified in the Privacy Rule, use or disclose protected health information without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

A. When and to the extent such use or disclosure is required by law.

B. For public health activities or public health oversight authorized by law.

C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.

E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, reporting crime in emergencies, or if the information constitutes evidence of criminal conduct on our premises.

F. For coroners, medical examiners, and funeral directors to perform their legal duties.

G. For procurement, banking or transplantation of cadaveric organs, eyes, or tissue.

H. For research purpose where there is appropriate documentation of an alteration to or waiver of the individual authorization required or such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.

J. For specialized government functions related to military personnel, veteran's benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.

K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.

L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

IV. **Authorization Required for Other Uses and Disclosures**. Uses and disclosures of protected health information other than those identified above will be made only with your written authorization. You may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon, or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or the policy itself.

V. **Individual Rights**. All participants have the following rights with respect to protected health information that the Plan maintains about them:

A. Restrictions on Uses and Disclosures. You may request that we restrict uses or disclosures of protected health information for the purposes of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care.

We are required to agree to your request only if the disclosure is for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) for a health care item or service for which you have paid the health care provider out-of-pocket in full.

Except as described above, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement with respect to protected health information created or received after we have notified you of the termination. Until then, we will be required to abide by the restriction unless the information is required for purposes such as giving you emergency treatment; assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name in a health care facility directory if you are incapacitated or in emergency circumstances; and circumstances described in Section II of this Notice in which an opportunity to agree or object need not be provided.

B. **Confidential Communications**. We must accommodate reasonable requests to have protected health information communicated to you in confidence by alternative means or at alternative locations. We may require your request to be in writing, state if appropriate how payment for the accommodation will be handled, specify an alternative method of contacting you, and state that disclosure of all or part of the protected health information could endanger you.

C. **Access for Inspection and Copying**. You may request access to inspect or copy protected health information that is maintained about you in a designated record set. If we grant your request, we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and costs to which you have agreed in advance for preparing an explanation or summary. If we deny your request in whole or in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other protected health information subject to your request.

We may in some circumstances deny your request without providing an opportunity for review, as when the information consists of psychotherapy notes or was compiled for use in a legal or administrative proceeding, and certain other circumstances. There are other circumstances in which we must provide an opportunity for review of our denial, as when the denial is based upon a determination that provision of the information is likely to cause substantial harm to you or another person. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contact Person identified in Section VII of this Notice if you believe our denial was improper.

D. **Amendments**. You may request amendments to protected health information maintained about you in a designated record set. If we accept your request in whole or in part, we must identify the information affected thereby, provide a link to the amendment, and make reasonable efforts to notify within a reasonable time persons disclosed by you or known to us who might foreseeably rely on the information to your detriment. We may deny your request if we determine that the information subject to your request is already accurate and complete, is not part of the designated record set, would not be available for inspection as described in Paragraph V(C) above, was not created by us, and in certain other circumstances.

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link to the request, our denial, and any statements of disagreement and rebuttal. We will also be required if asked by you to include your request for amendment and our denial with any future disclosures of the information subject to your request. If you submit a statement of disagreement, we will be required to include our request for

amendment, our denial, your statement of disagreement, and any rebuttal statement with any subsequent disclosure of the information to which the disagreement relates. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contact Person identified in Section VII of this Notice if you believe our denial was improper.

E. **Accounting of Disclosures**. You may obtain an accounting of our disclosures of protected health information about you during any period up to six years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same twelve-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

F. **Paper Copies of this Notice**. Regardless of the form in which you have chosen to receive this Notice from us, you may receive a paper copy at any time from the Privacy Contact Person identified in Section VII.

VI. **Changes to Privacy Practices**. We must change our privacy practices when required by changes in the law. We reserve the right to make other changes to our privacy practices or to this Notice that comply with the law. Whenever a change to our privacy practices materially affects the contents of this Notice, we will prepare a revised Notice and send it within 60 days to individuals then covered by the Plan. The Privacy Contact Person identified in Section VII will also provide a current copy of this Notice upon request. A change to our privacy practices that requires a revision of this Notice may not be implemented before the effective date of the revised Notice. However, we reserve the right to make the terms of any revised Notice effective for all protected health information that we maintain.

VII. **Additional Information and Complaints**. You may as specified below obtain additional information and/or submit complaints regarding our duties and your rights with respect to protected health information.

A. **Privacy Contact Person**. The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy Contact Person, whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice.

Benefit Programs Administration
Attn: Privacy Contact Person
1200 Wilshire Boulevard, 5th Floor
Los Angeles, CA 90017-1906
Phone: (562) 463-5000

B. **Privacy Complaints**. You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Person or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

C. **No Intimidation or Retaliation**. No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a Privacy Complaint.

VIII. **Effective Date**. This Notice shall become effective on January 1, 2018, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI.

PHI use and disclosure is regulated by federal law, 45 CFR parts 160 and 164 subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.

From: BOARD OF TRUSTEES
SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST
Privacy Contact Person's phone number: (562) 463-5000