Retiree Medical Plan of the Santa Monica Police Officers' Association Reimbursement Trust

September 1, 2022

Summary Plan Description

RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST

September 1, 2022

SUMMARY PLAN DESCRIPTION

This booklet is a summary of the Plan Document and intends to describe provisions regarding eligibility, reimbursement, suspension and termination of eligibility under the Retiree Medical Plan of the Santa Monica Police Officers' Association (SMPOA) Reimbursement Trust (hereafter, the "Plan"). This booklet, i.e, the Summary Plan Description (SPD), is not the Plan Document. In all cases (and even if there is a discrepancy between the SPD and the Plan Document), the provisions of the Plan Document will control and govern this Plan. For the complete provisions, request a copy of the Plan Document from the Plan Administrator below.

The Trustees shall have the authority and discretion to determine eligibility for reimbursement, to make factual findings, to fix ambiguities, to interpret and apply the provisions of this Plan, or of the benefit plans, 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 are entitled to offset (or recoup) any reimbursements that were paid to Retirees and Beneficiaries for which they were not otherwise eligible or for which they were incorrectly paid. The Trustees' decision shall be binding and conclusive.

I. Name of Plan

This Plan is known as the Retiree Medical Plan of the Santa Monica Police Officers' Association (SMPOA) Reimbursement Trust. The Plan is sponsored through the City of Santa Monica and the SMPOA.

II. Name, Address and Telephone Number of Plan Administrator

This Plan is administered by a third-party administrator (TPA) for the SMPOA Reimbursement Trust, the name, address and telephone number which is:

SMPOA Reimbursement Trust
c/o Benefit Programs Administration
1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017
(562) 463-5050
SMPOATrust@bpabenefits.com

Beneficiaries can also use the Drop Box available on the Trust's website at: www.smpoatrust.org

III. Identification Numbers

The Employer Tax Identification Number assigned to the Plan by the Internal Revenue Service is EIN 95-7011261.

The Plan number is 501.

IV. Type of Plan

This Plan is a welfare benefit plan, providing reimbursements for tax-deductible health insurance premiums and certain qualifying medical expenses (collectively, referred to as "Premiums" and as defined in Section 1.16 of the Plan). At times, health insurance premiums will also be referred to as "Insurance Premiums"; and qualifying medical expenses, such as for co-payments or the costs of prescription drugs will be referred to as "Expenses."

Generally, Insurance Premiums are defined in section 1.16(a) of the Plan and shall also include individual health coverage (or a Qualified Health Plan) for excepted benefits only (such as standalone dental or vision coverage) purchased through a state or federal insurance Exchange (Exchange) as set out in the Patient and Protection Affordable Care Act (PPACA). Insurance Premiums do not include any other type of individual health coverage (or a Qualified Health Plan) purchased through an Exchange as set out in PPACA.

The Plan does not reimburse for premiums for faith-based health ministries (unless they meet certain tax law requirements).

Qualifying medical expenses, such as for co-payments or the costs of prescription drugs will be referred to as "Expenses" and are defined in section 1.16(b) of the Plan.

V. Type of Administration

The Plan is administered by the Board of Trustees with the assistance of a third-party administrator. The address and telephone number of the TPA are listed in Item b.

VI. Name and Address for 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 Plan Trustee, the Board of Trustees or the TPA. Below are the names of the Trustees, their address, and their phone number:

Cody Green, Chairman

Adam Gwartz, Vice-Chairman

Daniel Larios, Trustee

Thomas Mastin, Trustee

Evan Raleigh, Trustee

Shane S. Talbot, Retiree Trustee

Steven Brackett, Retiree Trustee

P.O. Box 2160

Santa Monica, California 90407

(310) 393-1003

VII. Description of Bargaining Agreement

This Plan is maintained pursuant to a collective bargaining agreement, which is the "Memorandum of Understanding between the City of Santa Monica, and the SMPOA" (MOU), and applicable successor agreements. Beneficiaries of the Plan (i.e., employees, eligible retirees, surviving spouses, domestic partners and dependents), as defined in the Plan, may obtain copies of this MOU, upon written request to the Plan Administrator. Further, the MOU is available for examination by Beneficiaries at the Plan Administrator's office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the MOU. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

VIII. Participation, Eligibility and Reimbursements

A. Eligibility in the Plan is generally open to all employees who are members of the SMPOA (hereafter "Employees") and on whom the required contributions are made to the Trust. See Plan sections 2.1 and 2.2 for details.

B. Such employees become entitled to reimbursement of Premiums (as defined on page 2 above) of this Plan, generally, upon ceasing employment with the City of Santa Monica, earning seven years of Active Service, and attainment of age 50, assuming contributions have been made on behalf of the Employee for all periods of Active Service. See Plan sections 2.1- 2.2 for details.

C. Eligible Retirees are entitled to reimbursement of Premiums paid for coverage in effect on or after December 31, 2000 as defined in section 3.1 of this Plan. An "Eligible Retiree" is an Employee who is entitled to reimbursement under the Plan. The amount of reimbursement is based on the formula set forth in Plan section 3.2(a), also stated below.

1. The monthly reimbursement level of an Eligible Retiree will be the amount equal to the sum of the amounts described below in subsections: (1) Part "A" Reimbursement, and (2) Part "B" Reimbursement (less any applicable monthly administrative fees that the Trustees may assess in their discretion), as follows:

   a. The monthly Part "A" Reimbursement shall be equal to the years of active service of the eligible retiree, multiplied by 3.333 percent, multiplied by the base reimbursement amount (currently $200.00); provided however, that no more than 30 years of active service (including any Service as set out in section 2.2(b)) may count towards the monthly Part "A" Reimbursement.

   b. The monthly Part "B" Reimbursement shall be equal to the amount of the contributions per month on the retiree's behalf to the Trust, in excess of $67.00 per month, multiplied by 1.30 %.

   c. Reimbursement will only be made to the extent the retiree is eligible to receive such reimbursement.

d. No reimbursements will be paid in excess of the amount actually paid for Premiums by the beneficiary.

D. Annual Reimbursement Amount for Eligible Retirees Who Submit Expenses.

The Plan will reimburse Eligible Retirees an amount not to exceed twelve (12) times their Monthly Reimbursement Amount for Premiums, i.e., contributions to health care plans and for other qualifying medical expenses, which are incurred in a calendar year. These Monthly Reimbursement Amounts will be paid quarterly in (or for) the calendar year when the date of service occurred. The Annual Reimbursement Amount is only allowed where Premiums (as defined in section 1.16(b) of the Plan) are paid sporadically during a calendar year.

For example, if your maximum Monthly Reimbursement Amount is $200 per month ($2,400 annually), and your quarterly expenses are $150 in January, $250 in February and $350 in March; totaling $750 for the quarter, you will be reimbursed $600 for the quarter under the Plan. Assuming your expenses follow this pattern for the rest of the calendar year, you will be reimbursed up to $2,400 annually. Also note that if you pre-pay Premiums in December 2022 for the 2023 year, you will be reimbursed for those Premiums on a quarterly basis up to your maximum Annual Reimbursement Amount for the 2023 year.

E. Small Reimbursement Amounts for Insurance Premiums (set out in section 1.16(a) of the Plan). Provided your monthly premium reimbursement level is less than $200 and you satisfy the other criteria noted below, you will receive your monthly reimbursements in a single annual payment during the first quarter of the year (instead of in quarterly payments throughout the year). In addition to your monthly reimbursement (for Insurance Premiums only) being less than $200, you must satisfy the following:

- Be enrolled in the Annual Verification Program; and
- Submit the attendant annual documentation.

For example, if your maximum monthly premium reimbursement is $199 and the Trust receives all the required documentation, you will obtain a single annual payment of $2,388 Overpayments which may result due to death, or suspension or termination of reimbursements, will be subtracted from any subsequent payments due to you or your Dependents as provided in sections 3.4(f)(1) and 5.4 of the Plan.

F. Annual Verification Program.

1. An Annual Verification Program has been established, enabling you to receive automatic reimbursement for Premiums on a quarterly basis, provided your entire Monthly (or Annual) Reimbursement Amount includes:
   a. monthly Premiums paid for and reflected in your monthly CalPERS statements for health, vision, and/or dental contributions or premiums that meet or exceed your Monthly Reimbursement Amount; or
   b. a consistent pattern of paying the same or equivalent Premiums (whether monthly or annually) to the same provider(s) for major medical health

insurance, Medicare supplemental insurance, dental, vision, long term care, cancer, or medical accident, where such Premiums equal or exceed your Monthly (or Annual) Reimbursement Amounts, respectively.

2. Eligible Beneficiaries must enroll in such Annual Verification Program or otherwise an administrative fee of $25 will be deducted from each quarterly claims submission if they fail to so enroll.

G. Surviving Spouses and Dependents.

There are also reimbursements for Surviving Spouses and Dependents as set forth in Plan sections 2.2 through 3.3 and as described below:

The reimbursement level of a Surviving Spouse, or of surviving Dependents if there is no Surviving Spouse, will be 50% of the reimbursement level that the Employee had earned.

Notwithstanding the above, the reimbursement level of a Surviving Spouse with or without Dependents, or of surviving Dependents if there is no Surviving Spouse, of an Employee who dies due to an incident in the course and scope of his employment as an Employee, will be 100% of the reimbursement level that the Employee had earned. A Surviving Spouse with or without Dependents, whose Employee spouse dies due to an on-the-job incident, will commence receiving reimbursement in the month following the Employee's death even if that Employee had not attained age 50 or the Surviving Spouse has not attained age 50. In this event, reimbursement will be paid at 100% of the level that the Employee had earned, until the Surviving Spouse loses Surviving Spouse status as set out below or until all Dependents cease being Dependents or lose Dependent status.

Generally, reimbursements will terminate when the Surviving Spouse dies or remarries. Reimbursements will terminate when Child Dependents lose Dependent status. (See page 8 below for more details.) If the Surviving Spouse dies before the Dependents attain age 18, the reimbursement will be paid to the legal guardian of the children. Reimbursement will be paid to the legal guardian of a physically or mentally disabled Dependent, if applicable.

1. Definitions of Child Dependents and Spouses
   a. **Child Dependent** means the natural or lawfully adopted child of an Employee (or child placed in the Employee's home for adoption) or stepchild, who, at the time of an Employee's or Retiree's death, meets one of the following requirements:

      (i) Is a dependent under the age of 26; or

      (ii) Is an unmarried child of any age who is chiefly dependent upon the Employee for support and maintenance and is unable to care for himself by reason of mental or physical disability.

b. **Spouse**" means the lawful spouse of an Eligible Retiree to whom the Retiree was married on the date of the Retiree's retirement. Spouse does not include a divorced or legally separated spouse from the Retiree.

2. **Deaths or Retirements On or After November 1, 2019; and Definition of Surviving Spouse**

Effective November 1, 2019, revisions were made to track how CalPERS defines Surviving Spouses. If you are married and retire on or after November 1, 2019[1], only that spouse to whom you were married at the time of retirement will be considered a Surviving Spouse under the Plan. Also, if you are not married when you retire on or after November 1, 2019, any person you marry after you retire will not be eligible to receive reimbursements under the Plan.

For deaths on or after November 1, 2019, "Surviving Spouse" means the lawful spouse of a deceased Eligible Retiree to whom the Retiree was married on the date of the Retiree's death, provided the Surviving Spouse was also married to the Retiree at the date of retirement (and such retirements occur on or after November 1, 2019). Surviving Spouse shall also mean the lawful spouse of a deceased Employee, who had satisfied all the requirements of section 2.1 of the Plan, except that the Employee died prior to attaining age 50. Furthermore, if the Retiree was not married at the time of retirement (for retirements on or after November 1, 2019), and died thereafter, no reimbursement is payable to the Retiree's then surviving spouse under the Plan.

3. **Reimbursements Potentially Available to Surviving Spouse and Dependents if Employee Dies Before Becoming Eligible for Reimbursement**.

Effective January 1, 2019, in cases where an Employee dies prior to becoming eligible for reimbursement under this Plan, the Surviving Spouse or

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[1] **Deaths or Retirements Before November 1, 2019**

If the Eligible Retiree died or retired before November 1, 2019, the lawful spouse to whom the Eligible Retiree was married to on the date of death will be considered the Surviving Spouse under the Plan.

"*For Deaths Before November 1, 2019*, "**Surviving Spouse**" means the lawful spouse of a deceased Eligible Retiree to whom the Retiree was married on the date of the Retiree's death. Surviving Spouse shall also mean the lawful spouse of a deceased Employee, who had satisfied all the requirements of section 2.1 of the Plan, except that the Employee died prior to attaining age 50. If the Eligible Retiree died or retired before November 1, 2019, then "Surviving Spouse" means the lawful spouse of a deceased Eligible Retiree to whom the Retiree was married on the date of the Retiree's death.

Dependents may obtain reimbursement for Premiums, i.e., qualifying medical expenses up to the amount of the deceased Employee's contribution (not the City's contribution on behalf of the Employee); provided the Employee died while still actively employed by the City, was not otherwise eligible to receive reimbursement under the Plan, and neither his Surviving Spouse nor Dependents elect COBRA in a timely manner.

For example, if the Employee had paid $4,500 in employee contributions to the Plan, died while still actively employed by the City, was not otherwise eligible to receive reimbursement under the Plan; and neither his Surviving Spouse nor Dependents elect COBRA in a timely manner, the Plan will reimburse all eligible medical expenses incurred by the Surviving Spouse and/or Dependents up to $4,500.

H. There are also reimbursements for domestic partners (defined in Section 1.8 of the Plan) as set forth in Plan Sections 2.2 through 3.3 and as described below:

The reimbursement level of a domestic partner will be the balance of the reimbursement level paid to the retiree under section 3.2(a) of the Plan and as stated above; and

Furthermore, the aggregate amount paid to all domestic partners annually shall not exceed the maximum amount allowed to domestic partners under federal tax law (currently set at 3% of the total benefits paid annually); which shall be calculated within thirty days after the end of each Plan year.

IX. Procedures Governing Qualified Medical Child Support Order Determinations (QMCSO)

Beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator (Noted in item b).

X. Description of Cost Sharing Provisions

This Plan reimburses toward the cost of "Premiums" as defined on page 2 above and in Section 1.16 of the Plan.

Plan Beneficiaries will be responsible for the balance of any Premiums not paid by the Plan's reimbursement level.

XI. Circumstances Which May Result in Ineligibility or Denial of Reimbursements or Amendment or Termination of the Plan

A. Circumstances which may result in disqualification, ineligibility, denial or the loss of reimbursements include: failure to make required contributions; failure to properly submit expense receipts; failure to meet the eligibility requirements; submission of premiums that are not tax deductible (such as those for faith based ministries); submission of expenses that cannot be deemed qualifying medical expenses; death; temporary suspension while working as an Employee after retirement; or termination of the Plan.

An Eligible Retiree's reimbursement coverage under the Plan shall also terminate on the first to occur of the following:

1. The date the Retiree again becomes an "Employee" as defined in the Plan, although eligibility resumes upon termination of such employment; or
2. The date of the Retiree's death, although claims for Premiums incurred prior to death, which are properly and timely submitted will be paid; or
3. The date the Retiree again becomes employed by any employer and elects to receive cash in lieu of health coverage offered by the Retiree's employer, and/or the Retiree's Spouse elects to receive cash in lieu of health coverage offered by the Spouse's employer. Upon such an election, the monthly reimbursement received by the Retiree and/or the Spouse under this Plan shall be reduced by the monthly amount of the cash benefit received by the Retiree and/or the Spouse under their plans. In other words, the cash in lieu plan(s) shall be the primary plan(s) to pay for the Retiree and the Spouse's monthly qualifying medical expenses (defined as "Premium" in section 1.16 and that are otherwise allowable and payable by this Plan). Only if the monthly cash benefits (under the cash in lieu plans) are less than the monthly qualifying medical expenses that were incurred, shall this Plan reimburse such remaining Premiums up to the level of the Retiree's monthly reimbursement amount. If the Retiree and/or Spouse receive or elect any cash benefit (in lieu of health coverage) to be paid in either a lump sum or in a sum paid for the year, the aggregate (total) of those cash in lieu benefits will be pro-rated over 12 months and that pro-rated monthly benefit will used to reduce your monthly reimbursements from this Plan.

   The monthly reimbursement reduction shall remain in force for as long as the Retiree and/or Spouse receive or elect to receive such cash benefit from their employers. Where the Retiree and/or Spouse received or elected to receive any cash benefit to be paid in either a lump sum or in a sum paid for the year, the monthly reimbursement reduction shall remain in force for the year for which such a cash benefit is received. For purposes of this provision, no monthly reimbursement shall be made under this Plan when the monthly cash benefits (under the cash in lieu plans) exceed the monthly qualifying medical expenses that were incurred.

B. Surviving Spouse and Dependents' Termination

A Surviving Spouse's and a Dependent's reimbursement coverage shall terminate on the first to occur of the following:

1. The date of the Surviving Spouse's or Dependent's death, although claims for Premiums incurred prior to death, which are properly and timely submitted will be paid;
2. The remarriage of the Surviving Spouse;

3. If the remarriage does not result in other medical coverage for the surviving dependents, the Dependents will continue to receive 50% of the benefit described in Section 3.2(a) of the Plan. The eligibility of a domestic partner will terminate on the death of the eligible retiree who is the partner of the domestic partner; or

4. The end of the month in which the Dependent loses Dependent status. Generally Dependents lose Dependent status upon attaining age 26.

C. Domestic Partner's Termination

A Domestic Partner's reimbursement coverage shall terminate on the death of the Retiree who is the partner of the Domestic Partner.

D. Ability to Opt Out and Waive Premiums in this Plan

Annually, retirees will be given the option of electing to opt out of this Plan and waive any eligible Premiums (as defined on page 2 above and in Section 1.16 of the Plan) to which they would have been otherwise entitled during the year so that they may apply and receive a premium assistance tax credit in a Qualified Health Plan under a state or federal health insurance Exchange as set out in PPACA.

If a retiree obtains such a tax credit under such an Exchange, he must promptly notify the Plan of such in writing. In any event, the Plan will terminate eligibility of that retiree and will be entitled to offset (or recoup) any Premiums that the Plan paid to the retiree for which the retiree was not otherwise eligible.

XII. Additional Rights, Authority and Discretion Afforded to Board of Trustees

The Board of Trustees reserves the right to adjust the benefit amount, amend, modify, or terminate the Plan at any time.

The Trustees shall have the authority to impose reasonable penalties, suspensions or forfeitures upon Beneficiaries who: (a) falsify any information requested of them in the administration of the Trust or its benefit plans, (b) fail to provide requested information (e.g., employment information, medical records) reasonably requested to ascertain eligibility for reimbursement, or (c) fail to timely cooperate with the Trustees in administration of Plan reimbursement. The Trustees are entitled to offset (or recoup) any reimbursements that were paid to Retirees and Beneficiaries for which they were not otherwise eligible or for which they were incorrectly paid.

XIII. Distributions of Assets on Termination

In the event of the termination of the Plan, assets of the Plan which remain after expenses associated with such termination will be allocated among, and distributed to, the Beneficiaries according to the discretion of the Board of Trustees and in a manner that is consistent with the Plan.

XIV. Continuation Coverage for Qualified Beneficiaries Pursuant to COBRA

A. COBRA If you are covered by this Plan you have the right to continue contribution to this Plan, in order to receive coverage after retirement in certain instances where coverage under this Plan would otherwise end. This continued participation is a right governed by federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as your "COBRA" right. This notice is intended to inform you of your rights and obligations under COBRA. You, and your spouse if married, should take the time to read this notice carefully.

B. Qualifying Events If you are an Employee, and you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), these are called "Qualifying Events," which give you the right to continue contributions to the Plan.

If you are the spouse of an Employee covered by this Plan, you have the right to choose continued participation for yourself if you lose coverage under this Plan for any of the following four reasons, which also are "Qualifying Events":

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; and
3. Your spouse first becomes eligible for Medicare.

Dependent children of an employee covered by this Plan may also have rights to continue contribution to this Plan if coverage under this Plan is lost for any of the following Qualifying Events:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3. A parent first becomes entitled to Medicare; or
4. The dependent ceases to be a "dependent child" under this Plan.

A child who is born to or placed for adoption with an employee who is already receiving continuation coverage is also eligible for continued participation.

Note that under COBRA, divorce or legal separation of a covered Employee from his or her spouse is considered a qualifying event.

However, the Plan will **not** accept COBRA payments from divorced or legally separated spouses (or to domestic partners of terminated domestic partnerships), because this Plan does not reimburse benefits to: divorced or legally separated spouses; or to domestic partners of terminated domestic partnerships. No Trust monies can be used in whole or part to satisfy a community property claim. It is the covered Employee's responsibility to satisfy any and all community property claims with assets other than those involving Trust benefits.

C. Notice Requirements. Under COBRA, the employee or a family member has the responsibility to inform the Trust of a child losing dependent status under this Plan. This notice must be given in writing to the Trust Office within sixty (60) days after the Qualifying Event or within sixty (60) days after the date coverage would be lost, if later.

When the Trust is notified that one of these Qualifying Events has happened, it will in turn notify you that you have the right to choose to continue your contribution. You have at least sixty (60) days from the date you would lose coverage because of one of the Qualifying Events described above to inform the Trust that you want to continue participation.

If you do not choose to continue making contributions to this Plan, your coverage under this Plan will end.

D. COBRA Coverage Means the Right to Continue Contributions to the Plan. The type of continuation coverage in this type of plan is unusual. It means the employee's (or family member's) right to continue to self-pay the contributions that were being paid by the employer under the collective bargaining agreement[2]. These contributions are intended to entitle you to health premium reimbursements after retirement.

In this Plan, the Trust must have received seven (7) years of contributions during an Employee's active employment in order for the Employee to receive Premium reimbursements after retirement. Therefore, depending on how many years of contributions have been made on an Employee at the time of the Qualifying Event, it may be advisable for the Employee to continue to self-pay the contributions in order to become entitled to the retiree Reimbursements.

Widowed spouses, and dependent children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office for details.

E. Length of COBRA Coverage. The COBRA law requires that you be afforded the opportunity to maintain continuation coverage for thirty-six (36) months (three years) unless you lost coverage because of a termination of employment or reduction in hours. In that case, the required self-payment period is eighteen (18) months. The eighteen (18)-month period may be extended to thirty-six (36) months if a second event (divorce, legal separation, death or Medicare entitlement, but not termination of employment) occurs during that eighteen (18)-month period. In addition, if employer contributions terminate due to the employee's termination of employment or reduction in hours which occurs less than eighteen (18) months after the date an employee becomes entitled to Medicare benefits, the self-payment period for a spouse or dependent child is extended to thirty-six (36) months from the date of the employee's Medicare entitlement.

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[2] In a typical health plan, the COBRA right entitles the employee to self-pay contributions to continue to receive current health coverage. In contrast, this Plan does not pay coverage to active employees, but instead accepts contributions during active employment, which are being held by the Trust to purchase health coverage after the employee retires.

The eighteen (18)-month period may be extended for an additional eleven (11) months (for a total of twenty-nine (29) months) if an individual becomes disabled (as determined under the rules for Social Security disability benefits) within the first sixty (60) days of continuation coverage and the Trust Office is notified of the Social Security determination within sixty (60) days of the determination and before the end of the eighteen (18)-month period. The affected individual also must notify the Trust Office within thirty (30) days of a determination (for purposes of Social Security disability benefits) that the individual is no longer disabled. The eleven (11)-month extension applies to all disabled and non-disabled individuals entitled to continuation coverage as a result of the same event. Please note the cost you pay for the additional eleven (11) months will be approximately 50% higher than the cost for the first eighteen (18) months if the continuation participation includes the disabled individual and the continued participation would not be available in the absence of a disability.

F. Termination of COBRA Coverage. The COBRA law provides that your continued participation may be cut short of the full coverage period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

1. The Trust no longer maintains a group health plan;
2. The premium for your continued participation is not timely paid;
3. You become enrolled in Medicare; or
4. There has been a final determination that you are no longer disabled if you qualified for an extra eleven (11) months continuation coverage based on disability.

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

If you have any questions about COBRA, you should contact the Trust Office at 1200 Wilshire Boulevard, 5th Floor, Los Angeles, California 90017, phone (562) 463-5050 or by e-mail at SMPOATrust@bpabenefits.com.

You can also use the Drop Box available on the Trust's website at: www.smpoatrust.org

Also, if you have changed marital status, or you or your spouse have changed address, please notify the Trust office.

XV. Source of Contributions

Contributions to this Plan are made by the City of Santa Monica and by Employees based on the Memorandum of Understanding between the City of Santa Monica and the SMPOA.

XVI. Methods Used for Accumulation of Assets

Contributions are received by and held in trust by the Trust and they are invested with the assistance of a professional investor, utilizing investment policies and methods consistent

with objectives of the Plan, and Employee Retirement Income Security Act of 1974 (ERISA) requirements.

XVII. End of Plan Year

The Plan runs on a calendar year from January 1 to December 31.

XVIII. Procedures to be Followed in Presenting Claims for Reimbursements and Appeal Procedures for Denied Claims; Contractual Limitations To Bring Lawsuit Against Plan

The Plan's claim and appeal procedures can be furnished automatically, without charge, as a separate document. Pertinent claims and appeals provisions (e.g., sections 4.2 and 4.3) are also set out below. The claim procedures are contained in sections 4.1 and 4.2 of the Plan and the appeal procedures are contained in sections 4.3 and 4.4 of this Plan (in this booklet). The Trust is located at:

SMPOA Reimbursement Trust
c/o Benefit Programs Administration
1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017
(562) 463-5050
SMPOATrust@bpabenefits.com

Beneficiaries can also use the Drop Box available on the Trust's website at: www.smpoatrust.org. A Beneficiary is an Eligible Retiree, Surviving Spouse, Domestic Partner, or Dependent.

4.2 Acceptance or Denial of Claims by the Trust Office.

(a) Standard Claim Decision - Timing. The Trust Office shall consider each claim for Plan reimbursement and determine whether to grant or deny coverage under the Plan. Subject to Sections 4.2(b) and 4.3(c) below, the Trust Office shall send written notification of its decision to the Beneficiary not later than thirty (30) days after receipt of the Beneficiary's claim. If coverage is granted, the Beneficiary shall receive payment. If the claim is denied, the Beneficiary has the right to appeal the claim, pursuant to Section 4.3 hereof and the Plan's "Appeal Procedures," if any, available from the Trust Office.

The denial notification shall include the following information:

(i) The specific reason(s) for such denial;

(ii) Specific reference to the Plan provisions upon which the denial is based;

(iii) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary's claim for reimbursement; and

(iv) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits and a statement of the Beneficiary's right to bring an action under ERISA Section 502(a), after exhausting the Plan's appeal procedures.

(b) Extension of Time - Special Circumstances. If the Trust Office determines that special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the Beneficiary prior to the termination of the initial thirty (30) day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trust Office expects to render a claim determination. In no event shall such extension exceed a period of fifteen (15) days from the end of the initial period (45 days total).

(c) Extension of Time — Failure to Submit Information. The period of time for the Trust Office to make a claim determination may be extended if the Beneficiary fails to submit all necessary information to allow the Trust Office to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Beneficiary until the date the Beneficiary provides to the Trust Office the requested information. The Beneficiary shall be allowed at least forty-five (45) days from receipt of the request for additional information within which to provide the information.

4.3 Appeal Procedures. Beneficiaries and any person who claims to be entitled to reimbursement under this Plan shall follow the provisions in Article IV of the Plan Document.

(a) Sole Procedures. The procedures specified in this Section shall be the sole and exclusive procedures available to a person dissatisfied with an eligibility determination or reimbursement award, or who is otherwise adversely affected by any action of the Trustees.

(b) Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in writing within one hundred eighty-one (181) calendar days after receipt of notification of the denial of reimbursement or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes that the grounds for denial

of reimbursement are inapplicable. The Beneficiary may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for reimbursement to the Trustees. The Beneficiary shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Beneficiary's claim for reimbursement.

(c) Decision on Appeal. No later than sixty (60) days after receipt by the Plan of the claimant's request for review of an adverse benefit determination, the Trustees shall issue a written decision, affirming, modifying or setting aside the former decision. Provided however, that if the claimant waives the sixty (60) day deadline, for the claimant's convenience in setting a hearing, then the Trustees shall have no more than thirty (30) days after the date of the hearing to issue the decision. Any notification of a denial of reimbursement shall include the following information:

(i) The specific reason(s) for such denial;

(ii) Specific reference to the Plan provisions upon which the denial is based;

(iii) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary's claim for reimbursement; and

(iv) An explanation of the Beneficiary's right to bring an action in federal court under ERISA Section 502(a), after exhausting the Plan's appeal procedures.

Right to Court Review; Time Limit to Bring Lawsuit

You have the right to bring action in federal court pursuant to ERISA Section 502(a) no later than two years after you exhausted or should have exhausted your administrative remedies (i.e., the appeal process described above and in section 4.3 of the Plan). To exhaust your administrative remedies means that you will have filed a claim, written an appeal, and received a written decision by the Board of Trustees on an appeal of a denied reimbursement claim or other complaint.

XIX. Statement of Legal Rights

A. Rights of Plan Participants. Beneficiaries of the SMPOA Reimbursement Trust are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the 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 and Security Administration.
2. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including, insurance contracts, if applicable, collective bargaining agreements, a copy of the latest annual report and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.
4. If there is a loss of coverage under this 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 this Plan on the rules governing your COBRA continuation coverage rights.

B. 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.

C. 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 but only 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 but only after exhausting the Plan's administrative

procedures. 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.

D. 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.

XX. Notice of Privacy Practices

A. General Information About This Notice. The Santa Monica Police Officers' Association Benefit Trust (the "Plan") is committed to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure and your privacy rights. This Notice only applies to health-related information created or received by or on behalf of the Plan. We are providing this Notice to you because privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA"), require us to provide you with a summary of the Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Plan information. We must follow the privacy practices that are described in this Notice while it is in effect.

In this Notice, the terms “Plan,” “we,” “us,” and “our” refer to the Plan and third parties to the extent they perform administrative services for the Plan. When third party service providers perform administrative privacy of your information.

CONTACT INFORMATION

If you have any questions regarding this Notice, please contact:

Santa Monica Police Officers’ Association Benefits Trust
c/o Benefits Programs Administration
1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017
Ph: (562) 463-5050
Fax: (562) 463-5894
Email: SMPOATrust@bpabenefits.com

B. Our Legal Duties. Federal law requires the Plan to have a special policy for safeguarding a category of medical information called "protected health

information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to identify you and that relates to:

- ***your physical or mental health condition,***
- ***the provision of health care to you, or***
- ***payment for your health care.***

Your reimbursement claims for medical, dental, and vision premiums and/or benefits, and any records pertaining to such claims for reimbursement are all examples of PHI.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Plan.

C. Uses and Disclosures of Your PHI. To protect the privacy of your PHI, the Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- ***To determine proper payment of your Health Plan benefit claims.*** The Plan uses and discloses your PHI to reimburse you for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse you for the medical care that you received.

- ***For the administration and operation of the Plan.*** We may use and disclose your PHI for numerous administrative and quality control functions necessary for the Plan's proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analyses for cost-control or planning-related purposes.

- ***To inform you about treatment alternatives that may be offered under the Plan.*** For example, we may use your claims data to alert you to an available case management program if you are diagnosed with certain diseases or illnesses, such as diabetes.

- ***To a health care provider if needed for your treatment.***

- ***To a health care provider or to another health plan to determine proper payment of your claim under the other plan.*** For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

- ***To another health plan for certain administration and operations purposes.*** We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- ***To a family member, friend, or other person*** involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency.

- ***For Plan design activities or to collect Plan contributions.*** The Plan may use summary or de-identified health information for Plan design activities such as underwriting. If we do use de-identified information for obtaining healthcare services bids or Plan design, we will not use any of your genetic information. In addition, the Plan may use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

- ***To the Plan Sponsor.*** The Plan may disclose PHI to the Plan sponsor, the Board of Trustees, to the extent provided by a rule of the Plan, provided that the sponsor protects the privacy of the PHI and it is only used for the permitted purposes described in this Notice.

- ***To Business Associates.*** The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates, and the Plan will have a written agreement with each of them requiring each of them to protect the privacy of your PHI. For example, the Plan may have its actuary evaluate reimbursement claims or suggest changes to the Plan, for which he needs to see PHI.

- ***Special Rule for Psychotherapy Notes.*** We will not disclose your psychotherapy notes without your written authorization, except to your psychotherapist for treatment, for our training programs, and to defend ourselves in legal actions brought by you.

- ***To comply with an applicable federal, state, or local law,*** including workers' compensation or similar programs.

- ***For public health reasons,*** including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

- ***To report a suspected case of abuse, neglect or domestic violence,*** as permitted or required by applicable law.

- ***To comply with health oversight activities,*** such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

- ***To the U.S. Department of Health and Human Services*** to demonstrate our compliance with federal health information privacy law.'

- ***To respond to an order of a court or administrative tribunal.***

- ***To respond to a subpoena, warrant, summons or other legal request*** if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.

- ***To a law enforcement official for a law enforcement purpose.***

- ***For purposes of public safety or national security.***

- ***To allow a coroner or medical examiner to make an identification or determine cause of death or to allow a funeral director to carry out his or her duties.***

- ***To respond to a request by military command authorities*** if you are or were a member of the armed forces.

- ***For cadaveric organ, eye or tissue donation.*** The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- ***For research.*** The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a privacy board or an Institutional Review Board has approved an alteration to or waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.

- ***To avert serious threat to health or safety.*** The Plan may use and disclose protected health information to prevent or lessen a serious threat to health or safety of any one person or the general public and the use or disclosure is (1) to a person or persons reasonably able to prevent or lessen the threat to health or safety or (2) necessary for law enforcement authorities to identify or apprehend an individual.

- ***Incident to a permitted use or disclosure.*** The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

- ***As part of a limited data set.*** The Plan may use and disclose a limited data set that meets the technical requirements of 45 Code of Federal Regulations, Section 164.514(e), if the Plan has entered into a data use agreement with the recipient of the limited data set.

- ***For fundraising.*** The Plan may use and disclose certain types of protected health information to a business or to an institutionally related foundation for the purpose of raising funds. The types of information that may be disclosed under this exception to the authorization requirement are: (1) demographic information relating to an individual and (2) dates of health care provided to an individual. The fundraising materials must inform you of how you may elect to opt out of receiving further fundraising communications that are healthcare operations. The entity that sends you such communications must treat your request to opt out as a revocation of your authorization to receive any such communications.

Absent your written permission, the Plan will only use or disclose your PHI as described in this Notice. The Plan will not access your PHI for reasons unrelated to Plan administration without your express written authorization.

If an applicable state law provides greater health information privacy protections than the federal law, we will comply with the stricter state law.

D. Other Uses and Disclosures of Your PHI. Before we use or disclose your PHI for any purpose other than those listed above, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

E. Your Rights. Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI to the extent necessary to pay Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. Except in the limited circumstances described below, the law does not require the Plan to agree to your request for restriction. Except as otherwise required by law (and excluding disclosures for treatment purposes), the Plan is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. The Plan will not agree to any restriction, which will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify

you that we are terminating the restriction with respect to PHI created or received by the Plan in the future.

You may make a request for restriction on the use and disclosure of your PHI by completing the appropriate request form available from the Plan.

Right to receive confidential communications: You have the right to request that the Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing an appropriate form available from the Plan. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of your PHI: You have the right to inspect and obtain a copy of your PHI that is contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format of your choosing — provided we can practicably provide it in that format —, and direct that such PHI be sent to another person or entity.

However, this right does not extend to (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) any information, including PHI, as to which the law does not permit access. We will also deny your request to inspect and obtain a copy of your PHI if a licensed health care professional hired by the Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

If you request copies of your health information, we will process the request within 30 days or provide an explanation for why that timeframe is too narrow and a date when the request can be processed.

In the event that your request to inspect or obtain a copy of your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Plan will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or obtain a copy of your PHI by completing the appropriate form available from the Plan. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete.

You may request amendments of your PHI by completing the appropriate form available from the Plan.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to you, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by you, (5) for directories or to people involved in your care or other notification purposes as permitted by law, (6) for national security or intelligence purposes, (7) to correctional institutions or law enforcement officials, (8) that are part of a limited data set, (9) that occurred more than six years before your request. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses.

You may make a request for an accounting by completing the appropriate request form available from the Plan.

Right to Receive Notice of Breach of Unsecured PHI: If the security of your unprotected PHI is breached, we will notify you about it.

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Plan's privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any evidence or documents that support your belief that your privacy rights have been violated. We take your complaints very seriously. **The Plan prohibits retaliation against any person for filing such a complaint.**

Complaints should be sent to:

Santa Monica Police Officers'
Association Benefit Trust
c/o Benefit Programs Administration

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100

1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017
Phone: (562) 463-5050
Fax: (562) 463-5894
SMPOATrust@bpabenefits.com

San Francisco, CA 94103
Phone: (800) 368-1019
FAX: (202) 619-3818
TDD: (800) 537-7697
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

F. Additional Information About This Notice.

Changes to this Notice: We reserve the right to change the Plan's privacy practices as described in this Notice. Any change may affect the use and disclosure of your **PHI** already maintained by the Plan, as well as any of your **PHI** that the Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of this Notice: You can obtain a paper or electronic copy of the current Notice by contacting the Privacy Officer at the address listed on the front of this Notice.

No change to Plan's reimbursement amounts: This Notice explains your privacy rights as a current or former participant in the Plan. The Plan is bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Plan. You should refer to the Plan documents for additional information regarding the Plan's reimbursement for retiree medical premiums and claims.