PREMIUM REIMBURSEMENT PLAN
FOR RETIREES

SANTA MONICA CITY EMPLOYEES COALITION
BENEFIT TRUST

Amended and Restated
Effective January 1, 2025

Draft 8/28/24 (incl. Plan Am. Nos. 1-10)

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PREMIUM REIMBURSEMENT PLAN FOR RETIREES

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PREAMBLE

WHEREAS, the City of Santa Monica and various groups and bargaining units representing employees of Santa Monica, which groups are signatory hereto (hereafter, the "Coalition"), entered into an "Umbrella Agreement, Medical Insurance for all Miscellaneous City Employees," approved by the City Council on June 12, 2001 and effective July 1, 2001, wherein the City and the Coalition agreed that contributions would be made to a benefit trust for the purpose of funding, in whole or in part, retiree health benefits for eligible City of Santa Monica retirees;

WHEREAS, the City and the Coalition further agreed that the contributions to the trust would be mandatory on behalf of every Employee in the participating bargaining units; and there would be no individual election on participation;

WHEREAS, the Coalition established such a Trust and granted administration of the Trust to a Board of Trustees pursuant to the Trust Agreement governing the Santa Monica City Employees Coalition Benefit Trust, effective July 1, 2001;

WHEREAS, the Board of Trustees adopted the Premium Reimbursement Plan, effective July 1, 2001, and the Board has periodically amended and restated the Plan and now wishes to incorporate Plan Amendment Nos. 6-10, along with various legal updates and correction of scrivener's errors, into a restated Plan.

NOW, THEREFORE, the Board of Trustees does hereby adopt this restated Premium Reimbursement Plan for Retirees, effective January 1, 2025, as set forth in the following pages.

SECTION 1. DEFINITIONS

Where the following words and phrases appear in this Plan, they shall have the meaning set forth in this Section, unless the context clearly indicates otherwise. Other words and phrases with special meanings are defined where they first appear unless their meanings are apparent from the context.

1.1 "Active Service" means service as defined in Section 2.2 herein, subject to Section 2.3 hereof.

1.2 "Association" means a participating labor organization or bargaining unit in the Coalition; and any other labor organization or bargaining unit that has signed a Memorandum of Understanding with the City, and for which the Trustees have approved participation in the Trust;

or any group that is the subject of a Special Agreement, and for whom the Trustees have approved participation in the Trust.

1.3 "Beneficiary" means an Eligible Retiree, his or her lawful spouse or Domestic Partner, and the Eligible Retiree's Children; an Eligible Retiree's Surviving Spouse or Domestic Partner and Surviving Children; and an Alternate Payee under a QDRO, but not to include any spouse of the Alternate Payee.

1.4 "Benefit Amount" means the amount set from time to time by the Trustees as the monthly maximum amount available for payment of Premiums, as set forth in Appendix A to the Plan.

1.5 "Board of Trustees" or **"Trustees"** means the duly selected board which administers the Plan and Trust, pursuant to the Trust Agreement.

1.6 "Child(ren)" means the natural child, stepchild, or adopted child of the Eligible Retiree, who is under the age of 26. **"Surviving Child(ren)"** means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Eligible Retiree's death and who continues to meet those requirements. Child(ren) or Surviving Child(ren) shall also include a natural child, stepchild, or adopted child of any age who is legally dependent upon the Eligible Retiree (or was legally dependent upon the Eligible Retiree at the time of the Eligible Retiree's death) for support and maintenance for so long as the child is determined to be totally disabled by the Social Security Administration. Surviving Child includes the Surviving Child of an Employee who has attained all requirements of Section 2.1, except that the Employee dies before attaining the eligibility age and/or while still employed by the City.

1.7 "City" means the City of Santa Monica, or any public agency (e.g., Rent Control Board) of the City that is party to a Memorandum of Understanding.

1.8 "Coalition" means the Santa Monica City Employees Coalition.

1.9 "Code" means the Internal Revenue Code, as amended.

1.10 "Contribution" means a mandatory monthly payment from the City to the Trust for each and every Employee in the bargaining unit represented by an Association, made pursuant to an MOU or Special Agreement and made without any election on the part of the individual Employee (except for contributions made pursuant to COBRA continuation requirements of federal law under IRC Section 4980B).

1.11 "Domestic Partner" means a person who meets all of the following requirements and, along with the Eligible Retiree, completes and signs an affidavit to this effect, approved by the Board of Trustees:

- 18 years of age or older;
- Shares the same permanent residence as the Eligible Retiree and intends 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.

1.12 "Eligible Retiree" means an Employee who is entitled to benefits under Section 2.1 of the Plan.

1.13 "Employee" means an individual employed as a Permanent Employee of the City, who is a member of a bargaining unit represented by a Coalition member or other Association and on whom the required Contributions are made to the Trust Fund pursuant to a Memorandum of Understanding. **"Permanent Employee"** means an individual actively employed by the City who is or will be eligible for City-provided medical insurance immediately following expiration of the City's waiting period for enrollment in such City-provided medical insurance.

"Employee" also means an individual who is a member of the Santa Monica City Council, who participates pursuant to a Special Agreement.

1.14 "Hire Date" means the date that an individual starts working for the City as a Permanent Employee.

1.15 "Memorandum of Understanding" or **"MOU"** means a written agreement between the City and an Association that requires mandatory contributions for each employee in the bargaining unit to a trust for retiree medical benefits, and subsequent amendments or successor agreements.

1.16 "Missing Participant" means an Employee, Eligible Retiree, Surviving Spouse, Surviving Domestic Partner, or known Surviving Child for whom the Trust Office has no address information on file in Trust records, or for whom Trust mail communications have been returned to sender without a valid forwarding address.

1.17 "Plan" means this separate written document, together with any amendments duly adopted by the Trustees.

1.18 "Premium" means an insurance premium payment paid on behalf of a Beneficiary to a health plan (*e.g.*, medical, dental, vision or pharmacy insurance plan), which qualifies as medical care under Code Section 213(d) and for coverage of the Beneficiary in effect while the Beneficiary is eligible for benefits under this Plan. Long-term care insurance premiums are considered Premiums to the extent the insurance premium payments are deductible under Code Section 7702B. Premium also includes payments that would qualify under this definition except that the payments were made with pre-tax income, provided that reimbursement of such Premiums paid with pre-tax income will result in taxable income to the Beneficiary.

1.19 "QDRO" or **"qualified domestic relations order"** means a qualified domestic relations order as defined in ERISA Section 206(d)(3)(B), 29 USC 1056(d)(3)(B). A domestic relations

order will not be treated as a QDRO until the Trust Office determines that it is a QDRO.

1.20 "QMCSO" or **"qualified medical child support order"** means a qualified medical child support order as defined in ERISA Section 609(a)(2)(A), 29 USC 1169(a)(2)(A).

1.21 "Special Agreement" means a written agreement between the City and the Trust that covers an objective class of Employees, that is not based on individual election into the Trust, and that obligates the City to make mandatory contributions to the Trust Fund for each Employee in such class, for the purpose of providing employee welfare benefits to the Employees covered by said Agreement, and their Beneficiaries, and any supplements, amendment, continuation, or renewal thereof.

1.22 "Surviving Spouse" or **"Surviving Domestic Partner"** means the lawful spouse or Domestic Partner of an Eligible Retiree who was in that status at least 12 months on the date of the Eligible Retiree's death. Surviving Spouse or Surviving Domestic Partner includes the Surviving Spouse or Surviving Domestic Partner of an Employee who has attained all requirements of Section 2.1, except that the Employee dies before attaining the eligibility age and/or while still employed by the City.

1.23 "Trust" or **"Trust Fund"** means the Santa Monica City Employees Coalition Benefit Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records.

1.24 "Trust Agreement" or **"Agreement"** means the Trust Agreement governing the Santa Monica City Employees Coalition Benefit Trust, effective July 1, 2001, and any amendments thereto.

1.25 "Trust Office" means the administrative agent selected by the Board of Trustees.

SECTION 2. ENTITLEMENT TO BENEFITS

2.1 **Eligible Retiree**. An Employee shall become an Eligible Retiree when he or she meets all the conditions set forth in subsections (a) through (d) as follows:

(a) For an Employee whose Hire Date is prior to January 1, 2009, that Employee must earn five years of Active Service as defined in Section 2.2 below.

For an Employee whose Hire Date is after December 31, 2008, that Employee must earn ten years of Active Service as defined in Section 2.2 below; and

(b) The Employee attains age 58, or dies before age 58 for survivor benefit eligibility;

(c) The Employee ceases employment with the City of Santa Monica on or after the date he or she becomes age eligible to receive service retirement benefits, as defined by CalPERS, or the Employee dies while still employed by the City for survivor benefit eligibility; and

(d) Contributions have been made to the Plan for all Active Service of the Employee, as defined in Section 2.2, since inception of the Plan on July 1, 2001, or Hire Date, if later.

2.2 Active Service.

(a) Bargaining Unit Service. Active Service is used to determine an Employee's eligibility under this Plan. An Employee may earn Active Service in the following ways:

(1) For each month of employment as an Employee after June 30, 2001, for which the Trust receives Contributions (except no contributions will be required for a period of up to 60 days immediately following the Hire Date, but these 2 months will still be counted as Active Service);

(2) For time as an Employee on any authorized leave of absence from the City, including authorized disability, illness, or injury, provided that Contributions are made to the Plan during that time, either by the City or pursuant to Section 2.2(b); and

(3) For service in the Armed Forces, for the period required by federal law to allow continued participation, provided that contributions are made to the Plan during that time.

(b) Contribution after Termination or Reduction of Employment. An Employee whose employment is terminated, or hours reduced, which causes Contributions to cease, may continue to earn Active Service by monthly self-payment of contributions, for a maximum of 18 months, pursuant to the federal COBRA law and rules set by the Trustees.

(c) Spouse or Child Contribution after Employee Death, Divorce from Employee, or Child Age Out of Benefit Eligibility. After death of an Employee or divorce from an Employee, a Surviving Spouse, Surviving Domestic Partner or Child may continue to earn Active Service by monthly self-payment of contributions, for a maximum of 36 months, pursuant to the federal COBRA law and rules set by the Trustees. A Child who is currently eligible for benefit payments and attains age 26 may continue to receive benefits by monthly self-payment of COBRA contributions for a maximum of 36 months.

2.3 No Rebate or Refund. Beneficiaries shall receive benefits from the Plan only as reimbursement of Premiums. No Beneficiary or Employee shall be eligible for rebates or refunds of any contributions made, except as reimbursement of Premiums. As permitted by applicable law and approved by the Board of Trustees, any elective contributions (other than under COBRA or USERRA) will be refunded upon discovery that the contribution was made by individual election. Beneficiaries are not entitled to Active Service or eligibility based upon an elective contribution, regardless of whether the contribution is refunded.

SECTION 3. BENEFITS

3.1 General.

(a) Subject to the exclusions and limitations set forth in this Plan, a Beneficiary is entitled to the reimbursement of Premiums for coverage in effect on or after July 1, 2006, for one or more Beneficiaries, subject to proper documentation, in an amount not to exceed the Benefit Amount in effect on the date of the claim payment to the Beneficiary. See Appendix A for a historical list of Benefit Amounts and their effective dates. The Trustees shall set the Benefit Amounts from time to time, and the Trustees may adjust the Benefit Amounts for some or all current and/or future Beneficiaries from time to time. The benefits of this Plan are not vested, and may be modified or terminated for some or all Beneficiaries, including current and/or future Beneficiaries.

(b) Carryover of Claims: Premiums Paid for Multiple Months of Coverage. A single Premium payment by a Beneficiary that is for multiple months of coverage will be reimbursed from the Benefit Amount of each month of coverage.

(c) No Carryover of Unused Monthly Benefit Amount. If a Beneficiary does not submit a claim for Premiums for insurance coverage in effect in a particular month that is equal to or greater than his or her Benefit Amount for that month, then the unused balance of the Beneficiary's monthly Benefit Amount for that month shall not be carried over to the next month.

(d) Recoupment of Overpaid Benefits. If the Trust overpays benefits to a Beneficiary, or if a Beneficiary does not timely submit a completed claim form and documentation required under Subsections 3.5(a) through 3.5(c) for reimbursement of Premiums, the Trust Office, as directed by the Trustees, shall have the right to request repayment of the overpayments or unsubstantiated reimbursements from the Beneficiary. If the Beneficiary fails to repay the Trust for the amount of the overpayment or unsubstantiated reimbursement, the Trust Office, as directed by the Trustees, shall have the right to recoup the overpaid or unsubstantiated amount from the Beneficiary's future benefit payments or request direct repayment from the Beneficiary. The Beneficiary shall be obligated to repay the Trust for the overpaid benefits, including unsubstantiated reimbursements, as requested by the Trust Office and allowed by law. Effective for Premiums for 2025 insurance coverage, if a Beneficiary submits the claim form and documentation required by Subsections 3.5(a) through 3.5(c) late, but otherwise in compliance with those Subsections, the Trustees may at their sole discretion forego recoupment of all or some of the overpaid benefits that were substantiated late.

3.2 Benefit Amount.

(a) Eligible Retirees. The Trustees shall determine the Benefit Amounts for Eligible Retirees and the effective dates thereof, as listed in Appendix A hereto and incorporated herein by reference.

(b) Surviving Spouses and Surviving Children. The Benefit Amount for a Surviving Spouse shall be 100% of the Benefit Amount for the Eligible Retiree. If there is no Surviving Spouse or Domestic Partner, and there are Surviving Children, the Benefit Amount of the Surviving Children shall be 50% of the Benefit Amount of the Eligible Retiree (to be divided among the Children submitting claims). There shall be no survivor benefits for the family or dependents of an Alternate Payee on the death of the Alternate Payee, except that the Children from the marriage of the Eligible Retiree and Alternate Payee shall continue to have Surviving Child benefits calculated based on the benefit level of the Alternate Payee, which shall commence as stated in Section 3.3(d) hereof.

(c) Surviving Domestic Partners.

(1) The Benefit Amount for a Surviving Domestic Partner shall be the same as for a Surviving Spouse, subject to subsection (2) hereof.

(2) The aggregate amount paid to all Domestic Partners annually shall not exceed the maximum amount allowed to Domestic Partners under federal tax law, as other benefits (currently set at 3% of the total benefits paid annually), which shall be calculated within 30 calendar days after the end of each Plan year.

(d) Alternate Payees Under QDROs. The monthly benefit level for an Alternate Payee pursuant to a QDRO will be determined as described in this section. A QDRO may award an Alternate Payee a portion of the Employee's or Eligible Retiree's Benefit Amount.

(1) Designation of Portion of Benefit Amount and Actuarial Adjustment. A QDRO may designate a fixed amount or a percentage of the Employee's or Eligible Retiree's Benefit Amount earned during the marital period, as defined in the QDRO, to the Alternate Payee. No other method of division of the Employee's or Eligible Retiree's monthly benefit shall be permitted. The Trust Office, in consultation with the Plan's actuary, shall convert the Benefit Amount thus designated for the Alternate Payee into an actuarially adjusted benefit level of the Alternate Payee, based on the Alternate Payee's age and the month that commencement of benefits is first available to the Alternate Payee.

(2) Modification of Alternate Payee Benefit Level. The benefit level of the Alternate Payee shall change from time to time, based on changes to the Benefit Amount and otherwise, in the same manner and percentage as the Employee's or Eligible Retiree's monthly benefit changes. These changes may occur before or after the commencement of benefit payments to the Alternate Payee.

(e) Adjustments. The Trustees reserve the exclusive right and power to adjust the benefit levels up or down. Such adjustments or termination may apply to some or all current and/or future Beneficiaries.

3.3 Commencement of Benefits.

(a) Retiree. An Eligible Retiree shall be entitled to benefits upon meeting the eligibility requirements of Section 2.1.

(b) Surviving Spouse or Surviving Domestic Partner. A Surviving Spouse or Surviving Domestic Partner shall be entitled to benefits starting the month after the Eligible Retiree's death, or the month after the Employee would have attained age 58, whichever is later.

(c) Surviving Children. Surviving Children shall be entitled to benefits upon death of the Eligible Retiree.

(d) Alternate Payee under QDRO. An Alternate Payee, pursuant to a QDRO, may commence receiving benefits at a time specified in the QDRO, but no earlier than the earliest date the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the City on such date. The Surviving Children of the marriage of the Eligible Retiree and Alternate Payee shall commence receiving benefits based on the Alternate Payee's benefit level starting the month after the death of the Alternate Payee.

3.4 Termination of Benefits.

(a) Eligible Retirees. Benefit payments to an Eligible Retiree shall be terminated on date of death, or the date that the Eligible Retiree again becomes employed by the City. Provided however, upon cessation of all employment with the City, benefit payments shall resume. A Surviving Spouse, who is also an Employee, shall be eligible to receive Surviving Spouse benefits regardless of employment with the City.

(b) Surviving Spouse or Domestic Partner. The coverage of a Surviving Spouse or Domestic Partner under the Plan shall terminate on the date of the Surviving Spouse's or Domestic Partner's death, although claims for Premiums for coverage prior to death, which are properly submitted, will be paid.

(c) Surviving Children. Surviving Children shall be entitled to benefits until death or loss of Child status, as defined in Section 1.6 hereof.

(d) Alternate Payee Under QDRO. The benefits for an Alternate Payee under a QDRO shall terminate on the first of the month following the date of the Alternate Payee's death. An Alternate Payee's benefit shall not be suspended if the Employee on whom it is based returns to employment with the City.

(e) Lifetime Benefits Not Guaranteed. The Plan is currently written to provide benefits for Eligible Retirees and Surviving Spouses until death. However, this is not guaranteed. Benefit coverage may be modified or terminated pursuant to Sections 3.2(e) or 6 hereof. The Trustees reserve the right to modify, limit, or terminate benefits as

necessary to preserve the financial soundness of the Plan. Such changes may apply to some or all current and/or future Beneficiaries, and may apply whether or not the Plan terminates.

3.5 Benefit Claim Procedure.

(a) Basic Claim Documentation. To make a claim for Plan benefits, Beneficiaries must present a completed claim form approved by the Trustees and documentation of the following:

(1) Date of insurance coverage;

(2) Type of healthcare insurance coverage, e.g., medical, dental, vision, pharmacy, or long-term care insurance; and

(3) Proof of the Beneficiary's payment of each monthly Premium, which complies with the standards of Subsection 3.5(b) below, and on the applicable schedule pursuant to Subsection 3.5(c)(2) through (4) below.

Prior to issuing a claim payment, the Trust Office shall review such proof and determine whether to grant or deny coverage under the Plan. Documentation of a recurring monthly Premium that is the same each month must be submitted as indicated in Subsection 3.5(c). If documentation of recurring Premiums is not sufficient, or monthly proof of payment is not received by the annual deadline in Subsection 3.5(c)(2), the Trust Office will suspend recurring benefit payments until sufficient documentation is received, and the Trustees have the right to recoup overpayments made due to insufficient documentation, pursuant to Section 3.1(d) hereof.

(b) Proof of Payment of Premiums. As determined by the Trustees in their sole discretion, proof of payment of Premiums under Subsection 3.5(a)(3) shall include, but not be limited to:

(1) Canceled check drawn to the name of the medical insurance provider;

(2) Credit card or bank statement showing proof of payment to the insurance carrier;

(3) Receipt for payment from the medical insurance provider;

(4) Written confirmation of electronic payment to the insurance provider;

(5) Annual Social Security Administration or Railroad Retirement Board statement showing Medicare premium payment deduction; or

(6) Pension plan statement, including CalPERS statement, showing premium payment deduction.

(c) Documentation Necessary for Recurring Premium Reimbursement. If a Beneficiary is paying Premiums monthly, there are two separate deadlines: January 31 of the Plan year of insurance coverage for items listed in Subsection (1) below; and January 31 of the Plan year following insurance coverage for items listed in Subsection (2) below. See Subsection 3.5(c)(3) for required proof of payment of Medicare Premiums. See Subsection 3.5(c)(4) for Premiums paid annually.

(1) Documentation Due By January 31st of Plan Year of Insurance Coverage: Prior to First Monthly Premium Reimbursement. The following items must be received by the Trust Office by January 31 of the Plan year of the insurance coverage in order to initiate recurring monthly Premium reimbursement for the Plan year.

a. Completed and signed claim form;

b. Third-party documentation of the items in Subsection 3.5(a)(1) and (2); and

c. Proof of payment of January Premiums or annual Premium payment (see Subsection (4) below).

If sufficient documentation is not received by the deadline, claims payment will be suspended until sufficient documentation is received. After sufficient documentation is received, the Trust Office will initiate recurring monthly Premium reimbursement and retroactively pay prior monthly benefits for the current Plan year, as needed. If a Beneficiary's Premium amount changes during the Plan year, the Beneficiary must notify the Trust Office and submit the above-listed items for the new Premium, including proof of payment of the first month's Premium.

(2) Documentation Due By January 31st of Plan Year Following Insurance Coverage: Proof of Payment of Remaining Eleven Months of Premiums. For Premiums for insurance coverage in effect on or after January 1, 2025, for each monthly Premium reimbursed by the Plan, except Medicare Premiums substantiated pursuant to Subsection 3.5(c)(3) below, the Trust Office must receive documentation of proof of payment of Premium(s), satisfying the requirements of Subsection 3.5(b), showing proof of the Beneficiary's payment of the same monthly Premium(s) amount that the Beneficiary claimed and documented pursuant to the annual documentation requirements in Subsection 3.5(c)(1) above. This documentation of proof of payment of all remaining 11 months of Premiums reimbursed in a Plan year must be received by the Trust Office no later than January 31 of the Plan year following the insurance coverage. 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.

(3) Documentation of Medicare Premiums. Subsection 3.5(c)(2) does not apply to Medicare premiums paid through deduction from social security or railroad retirement payments. For reimbursement of recurring monthly Medicare Premiums deducted from the Beneficiary's social security or railroad retirement payments, the Trust Office must receive, at least annually, by the deadline in Subsection 3.5(c)(1), the Beneficiary's annual Social Security Administration or Railroad Retirement Board statement showing the amounts deducted for Medicare premiums.

(4) Premiums Paid Annually. Subsection 3.5(c)(2) does not apply to Premiums paid in a single annual payment. Claims for annual Premium payments are subject to the requirements and deadlines in Subsection 3.5(c)(1) and paid from the monthly Benefit Amount of each month of coverage, pursuant to Subsection 3.1(b) hereof.

(d) Benefits Personal to Beneficiary. If the Trust Office grants coverage on the Beneficiary's claim, all Plan benefits are personal to the Beneficiary and payable only to the Beneficiary, except as provided in subsection 3.5(g) regarding Beneficiary deemed to be incompetent, or pursuant to a QDRO or QMCSO under federal law. If the Trust Office denies coverage, in whole or in part, the Beneficiary may appeal the denial of coverage or any other adverse benefit determination of the Plan, by taking action pursuant to Section 4.3 hereof.

(e) Beneficiary Priority for Claim Payment. Claims submitted in the same month for reimbursement of Premiums of multiple Beneficiaries in the same family shall be prioritized for payment from the monthly Benefit Amount in the following order, in 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.

(f) Authority to Submit Claims. Only an Eligible Retiree or Surviving Spouse or Surviving Domestic Partner may submit claims for reimbursement of Premiums of a Beneficiary from the Benefit Amount of the Eligible Retiree, or Surviving Spouse or Surviving Domestic Partner. If there is no Surviving Spouse or Surviving Domestic Partner or the Surviving Spouse or Surviving Domestic Partner is not yet eligible for benefits, a Surviving Child may submit claims for reimbursement of his or her own Premiums. An Alternate Payee shall have authority to submit claims for Premiums of Children from the marriage of Eligible Retiree and Alternate Payee for reimbursement from the Alternate Payee's Benefit Amount, and the Children of the marriage of Alternate Payee and Eligible Retiree shall have authority to submit claims for reimbursement from the Alternate Payee's Benefit Amount following death of the Alternate Payee.

(1) Delegation of Authority to Submit Claims. An Eligible Retiree may delegate authority to submit claims to his or her legal spouse by completing and submitting to the Trust Office a form approved by the Trustees for that purpose. Similarly, a Surviving Spouse may delegate the authority to submit claims to a Surviving Child by completing and submitting to the Trust Office a form approved by the Trustees for that purpose.

(2) Revocation of Authority to Submit Claims. An Eligible Retiree or Surviving Spouse may revoke authority granted pursuant to Subsection 3.5(f)(1) hereof at any time by submitting a written revocation (including via email) to the Trust Office.

(g) Incompetent Beneficiary. If a Beneficiary is deemed to be incompetent by a lawful judicial forum, then the Trust Office may pay any benefit claims payment to the person that the judicial forum has appointed as the Beneficiary's representative, and the Beneficiary's representative may submit claims and take action on the Beneficiary's behalf, subject to the requirements of this Section 3.5. The Trustees shall not be under any duty to oversee the application of funds so paid, and receipt by the Beneficiary's representative shall be full acquittance to the Trustees, the Trust Office, and the Plan.

(h) Enforcement of Clarification of Rights. A Beneficiary or Employee who does not have a claim for current Premiums, but seeks to enforce his or her rights under the terms of the Plan or seeks to clarify his or her rights to future benefits or eligibility under the terms of the Plan, may submit a written request to the Trust Office explaining his or her position and asking for a decision or clarification. The Beneficiary or Employee should enclose any relevant documentation supporting the request. If the Beneficiary or Employee is not satisfied with the decision of the Trust Office, the Beneficiary or Employee may request an appeal of the Trust Office decision to the Board of Trustees pursuant to Section 4.3 hereof.

3.6 Prohibition of Assignment and Protection from Creditors.

(a) No Assignment or Encumbrance of Benefits. No benefit payment under this Plan shall be subject in any way to assignment, alienation, sale, transfer, pledge, attachment, garnishment, or encumbrance of any kind. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish, or encumber the benefits or monies due from this Plan, whether for current or future benefits, shall be void. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any right or interest under this Plan for part or all of the Employee's or Beneficiary's current or future benefit payments. Any such arrangement shall be void under this Plan.

(b) No Assignment of Rights under Law. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish or encumber the Employee's or Beneficiary's rights under this Plan shall be void,

including but not limited to, the right to bring any action in court, file a lawsuit or appeal a coverage determination, the right to enforce rights or eligibility under the Plan, the right to benefits or eligibility under the Plan, the right to clarify rights to future benefits or eligibility under the Plan, and the right to request copies of Plan documents or annual reports. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any such right. Any such arrangement shall be void under this Plan.

(c) Protection of Benefits from Creditors. The Plan and Fund are exempt from all claims from creditors or other claimants and from all orders, decrees, garnishments, executions, and legal processes or proceedings, except in connection with qualified medical child support orders or qualified domestic relations orders.

SECTION 4. CLAIM APPEAL PROCEDURES

4.1 Beneficiary's Duty to Notify Trust Office of Claim. The Beneficiary is required to notify the Trust Office of his or her claim for benefits pursuant to Section 3 hereof before he or she is entitled to either receive benefits under this Plan, or appeal the Trust Office's decision denying a request for benefits.

4.2 Acceptance or Denial of Claims by the Trust Administrator.

(a) Standard Claim Decision – Timing. The Trust Office shall consider each claim for Plan benefits and determine whether to grant or deny coverage under the Plan. Subject to Sections 4.2(b) and 4.2(c) hereof, the Trust Office shall send written notification of its decision to a Beneficiary not later than 30 days after receipt of the Beneficiary's claim. This 30-day period shall commence upon the Trust Office's receipt of a claim form or other request for reimbursement from the Beneficiary, irrespective of whether the Beneficiary has provided all of the documentation and information necessary for it to determine the claim. If coverage is granted, the Beneficiary shall receive payment pursuant to Section 3.5. 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:

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

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

(3) 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 benefits;

(4) A description of any additional material or information necessary for the Beneficiary to perfect the claim and an explanation of why such material or information is necessary;

(5) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to a Beneficiary upon request;

(6) 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; and

(7) A description of the Plan's limitation period for filing a lawsuit against the Plan for benefit payments, as stated in Section 4.4(b) hereof.

(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 30-day period referenced in Section 4.2(a) hereof. The Trust Office's extension notice shall: (i) inform the Beneficiary that it needs the extension; (ii) explain the special circumstances that require the extension; (iii) identify any additional information it may need from the Beneficiary (if the extension is needed due to insufficient information); and (iv) confirm the date by which the Trust Office expects to render a benefit determination. In no event shall such extension exceed a period of 15 days from the end of the initial 30-day period. In the event that additional information is needed from the Beneficiary and the Beneficiary fails to submit all necessary information and documentation to allow the Trust Office to decide the claim by the end of the tolling period in Section 4.2(c) hereof, the Trust Office may not further extend the time for making its decision on the claim, unless the Beneficiary agrees in writing to further extend the deadline.

(c) Tolling of Claim Determination for Time to Submit Claim Information and Documentation. The Beneficiary shall be allowed at least 45 days from his or her receipt of the Trust Office's request for additional information within which to provide the Trust Office with the additional information requested. In such case, the 15-day extension period, and any remaining portion of the initial 30-day period for the Trust Office to decide the claim, is tolled from the date on which the request for additional information is received by the Beneficiary. This tolling period shall expire on the earlier of: (i) the date that the Trust Office receives a response from the Beneficiary, without regard to whether the Beneficiary's response provides all of the information and documentation requested and necessary for the Trust Office to decide the claim; or (ii) the date of the deadline established by the Trust Office for the Beneficiary to furnish the requested information (*i.e.*, at least 45 days from the Beneficiary's receipt of the request). Nothing in this Section shall preclude the Beneficiary from voluntarily agreeing to provide the Trust Office additional time within which to make a decision on a claim.

4.3 **Appeal Procedures**. The Trustees, Beneficiaries and any person who claims to be entitled to benefits under this Plan shall follow the provisions in this Section 4.

(a) Exclusive Procedures. The procedures specified in this Section, together with any written hearing procedures adopted by the Trustees, shall be the exclusive procedures available to a person dissatisfied with an eligibility determination, benefit claim decision or response to written request pursuant to Section 3.5(h) hereof, or to a person 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 181 calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes that the grounds for denial of benefits 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 benefits 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 benefits.

(c) Hearing Procedures. If the Beneficiary requests a hearing, the Board of Trustees shall conduct a hearing, as required by applicable law. The Beneficiary shall be entitled to present his or her position and any evidence in support thereof at the hearing. The Beneficiary may be represented by an attorney or any other representative of his or her choosing at the Beneficiary's expense.

(d) Decision on Appeal. The Trustees shall issue a written decision, affirming, modifying or setting aside the former decision. Any notification of a denial of benefits 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 benefits; and

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

4.4 **Right to Court Reviews, Time Limit to Bring Lawsuit**.

(a) Exhaustion of Internal Appeal Procedures. An Employee or Beneficiary who is dissatisfied with an eligibility determination, benefit award, claim decision, or response

to written request, pursuant to Section 3.5(h) hereof, must first exhaust the procedures in this Section 4 before bringing an action in court.

(b) Limitation Period for Filing a Lawsuit Against the Trust. A Beneficiary has the right to bring action as described in Section 4.4(a) hereof in federal court, pursuant to ERISA Section 502(a), no later than one year after the exhaustion of administrative remedies, which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim, or other complaint described in Section 3.5(h).

SECTION 5. MISCELLANEOUS

5.1 Limitation of Rights. Neither the establishment of the Plan and the Trust, nor any modifications thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving any Beneficiary or other person any legal or equitable right of action, or any recourse against any Association, the Coalition, or its employees, the Trust or its employees, the Trust Office or the Trustees, except as provided in this Plan and the Trust Agreement.

5.2 Applicable Laws and Regulations. Reference in this Plan to any particular sections of any local, state or federal statute shall include any regulation pertinent to such sections and any subsequent amendments to such sections or regulations. Except where this Plan is subject to California law, this Plan and the Fund shall be guided by ERIA, 29 U.S.C. 1001, *et seq*.

5.3 Confidentiality. It is agreed and understood that each Beneficiary who applies for benefits under this Plan is entitled to the same rights and consideration, including the right of confidentiality, and the Trustees shall not be required to nor shall they reveal to any other persons, including the Coalition, its officers, agents or employees, any matters revealed to them in confidence by such Beneficiary in the course of his or her application for benefits, except to the extent required by law.

5.4 Trustee Authority. The Trustees shall have the exclusive authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of the Trust and this Plan, or of the benefit plans (including prior or predecessor 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' decision shall be binding and conclusive.

5.5 Divorce Court Orders: QDRO and QMCSO Review Costs and Procedures. The Trustees shall adopt reasonable procedures for accepting, evaluating, approving, and administering QDROs and QMCSOs. The Trust reserves the right to deduct the reasonable costs associated with determining whether a domestic relations order qualifies as a qualified domestic relations order (QDRO), or a medical child support order qualifies as a qualified medical child support order (QMCSO), from the benefits payable to the Eligible Retiree or Beneficiary, according to rules set by the Trustees.

5.6 Missing Participant Policies and Procedures. The Trustees shall establish policies and procedures for searching for Missing Participants and shall transmit those policies and procedures to the Trust Office. Each Employee and Beneficiary in this Plan has the duty to inform the Trust

Office of changes in his or her contact information, including, but not limited to, home address (or post office box), phone number (cell phone number if available), and email address.

5.7 **Domestic Partner Benefit Costs**. The Trust reserves the right to deduct the reasonable costs associated with administering Domestic Partner benefits and any taxes charged to the Trust as the result of reporting taxable income from Domestic Partner benefits from the benefits payable to the Domestic Partner, according to rules set by the Trustees.

SECTION 6. AMENDMENTS AND TERMINATION

Trust resources for payment of benefits consist of Contributions required by the current MOU, assets held in the Trust, and investment returns of the Trust investments. All benefits are paid from Trust assets, and the Plan's obligation to make any benefit payment shall be limited by amounts held in the Trust and the financial stability of the Plan at the time of the payment. In order that the Board of Trustees may carry out its obligation to maintain, within the limits of Trust resources, a program dedicated to providing benefits for all Beneficiaries, the Trustees expressly reserve the right, in their sole discretion, any time and from time to time, provided that such action does not violate federal discrimination law:

(a) To adjust the Benefit Amount.

(b) To amend or rescind any provision of this Plan.

(c) To terminate the Plan.

Amendments shall be made by action of the Board of Trustees pursuant to Article IV of the Trust Agreement, and any such changes may apply to some or all current and/or future Beneficiaries, as determined by the Board of Trustees.

SECTION 7. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

7.1 **General.** This Plan is subject to the Privacy Rule, as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule sets forth standards to ensure that personal health information is kept private. This Section 7 describes the conditions under which the Plan may disclose Protected Health Information ("PHI") to the Board of Trustees, and the permitted and required use of such information by the Trustees. For purposes of this Section 7, the term Protected Health Information or PHI shall have the meaning provided in 45 CFR § 160.103.

7.2 **Disclosure to the Board of Trustees.**

(a) Permitted Disclosure of Summary Health Information. Summary Health Information is information that summarizes claims history, claims expenses, or type of claims experienced by individuals for whom the Plan has provided benefits, which excludes all demographic information that identifies individual Beneficiaries or could

reasonably be used to identify an individual Beneficiary. The Trust Office, on behalf of the Plan, may disclose Summary Health Information to the Board of Trustees for the purpose of modifying, amending or terminating this Plan.

(b) Permitted Disclosure of Individual Participation or Enrollment Status. The Trust Office, on behalf of the Plan, may disclose to the Board of Trustees information on whether an individual is participating or enrolled in the Plan.

(c) Permitted Disclosure of PHI. The Plan may disclose PHI to the Board of Trustees in order for the Trustees to carry out plan administration functions for this Plan.

(d) Conditions for Disclosure of PHI to Board of Trustees. The Board of Trustees agrees that all Trustees individually, or the Trust Office on behalf of the Board of Trustees, will take, or avoid, the following actions regarding the use of PHI disclosed to the Board of Trustees:

(1) To not use or further disclose PHI other than as permitted or required by this Plan, or as required by law.

(2) To ensure that any agents of the Plan and Trust, including independent contractors and subcontractors, to whom the Trustees and Plan provides PHI, agree to restrictions and conditions required by federal law with respect to PHI.

(3) To not disclose PHI to Employers or Associations for employment related actions and decisions or in connection with any other benefit or employee benefit plan.

(4) To report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the Plan or federal law, of which the Trustees become aware.

(5) To make available to individual Plan participants access to their own PHI, amendment to their own PHI, and accounting of disclosures of PHI, to the extent required by 45 CFR §164.524 and 164.526.

(6) To make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

(7) Return or destroy all PHI received from the Plan that the individual Trustees maintain in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made.

(8) To limit the access and use of PHI to plan administrative functions for this Plan.

7.3 Security of Electronic PHI. The Board of Trustees shall reasonably and appropriately safeguard electronic PHI created, maintained, or transmitted to or by the Board of Trustees on behalf of the Plan. The Board of Trustees will:

(a) Ensure that the Trust Office, and any agent of the Trust or Plan, including a subcontractor, to whom the Plan provides PHI, agrees to implement reasonable and appropriate security measures to protect the information and comply with federal law.

(b) Implement processes that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI created, received, maintained or transmitted on behalf of the Plan to the Trustees.

(c) Report appropriately any security incident of which the Trustees become aware.

ADOPTED on November 7, 2024, and effective January 1, 2025.

For BOARD OF TRUSTEES,
SANTA MONICA CITY EMPLOYEES COALITION BENEFIT TRUST

DocuSigned by:
Carl Olson
6712CD7ED04F4AA...
Trustee Signature

Carl Olson
Print Name

DocuSigned by:
Mary Ann Yurkonis
8D48DBC8E5D2480...
Trustee Signature

Mary Ann Yurkonis
Print Name

APPENDIX A

The historical Benefit Amount, as set by the Trustees, is as follows:

For Benefits Paid on or after	Benefit Amount*
July 1, 2006	$200
July 1, 2007	$250
July 1, 2010	$275
July 1, 2013	$300
July 1, 2014	$325
July 1, 2016	$350
July 1, 2021	$400
July 1, 2024	$425

*The Trustees may modify the Benefit Amount for some or all current and/or future Beneficiaries at any time. The benefits paid to the Beneficiary cannot exceed the actual Premium paid by the Beneficiary.