HEALTH CARE EMPLOYEES/EMPLOYER

DENTAL AND MEDICAL TRUST

SUMMARY PLAN DESCRIPTION

JANUARY 2012

Dear Plan Members, Spouse and Dependent:

This document provides you with certain information regarding the Health Care Employees/Employer Dental and Medical Trust (the "Plan"). You should keep it with the brochures provided by the medical and dental plans in which you are enrolled. Currently, the Plan offers dental benefits through Delta Dental and Pacific Union Dental and medical benefits through one of four HMOs (Health Maintenance Organization): Blue Shield of CA, Health Net, Kaiser Permanente, and Chinese Community Health Plan and two PPOS (Preferred Provider Organization): Blue Shield of CA and Health Net of CA. The terms and conditions of your dental and medical benefits are as described in the documents provided by the plan in which you are enrolled. Those documents also provide the appeals process in the event you are dissatisfied with the dental or medical benefits you receive. The appeals process described in this booklet tells you how to appeal actions of the administration office with regard to your eligibility or any action of the Board of Trustees.

Only the full Board of Trustees is authorized to interpret the benefit plan described in this booklet. The Board has discretion to decide all questions about this Plan, including questions about your eligibility for benefits. No individual trustee, employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized the administrative office (Dublin Insurance Services, Inc.) to respond in writing to your written questions. If you have an important question about your benefits, you should write to the administrative office for a definitive answer.

As a courtesy to you, the administrative office also may respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If a material change occurs, you will receive a written notice explaining the change. Please be sure to read all plan communications and keep information about benefit changes with this booklet.

This Plan was established for the exclusive benefit of eligible participants and their eligible dependents. The Plan is intended to be maintained indefinitely. The Plan, however, may be amended by the Board of Trustees from time to time as may be deemed necessary. Payment of the benefits described in this booklet is at all times subject to the availability of funds in the Trust to which the employers make their contributions. Neither the Trust Fund nor the Trustees individually have any obligation to continue benefits if there are insufficient monies and assets in the Trust Fund to do so.

The Board of Trustees

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IMPORTANT PHONE NUMBERS

In many cases, you will receive better health benefits if you make informed decisions. If you have any questions about the Health Care Employees/Employer Dental and Medical Trust, contact the Plan Administrator for assistance. Important phone numbers and websites are listed below.

Administrator
Dublin Insurance Services
(925) 803-1880
(925) 803-8780 fax

Blue Shield of California
(415) 229-5000
HMO Members: 800-424-6521
PPO Members: 800-200-3242
www.blueshield.com or
www.mylifepath.com

Chinese Community Health Plan
(415) 397-3190
www.cchphmo.com

Fidelity Life Insurance Company
Special Insurance Services
(800) 767-6811

Health Net
(800) 522-0088
www.healthnet.com

Kaiser Foundation Health Plan
(800) 464-4000
www.kp.org

Symetra Financial/Select Benefits
(800) 497-3699
www.symetra.com

Delta Dental Plan of California
(415) 972-8300 or (800) 427-3237
www.deltadentalca.org

United HealthCare Dental (formerly Pacific Union Dental)
(800) 999-3367
www.uhc.com

Reliance Standard Life Insurance Company
(925) 210-1000
www.rsli.com

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. That information is as follows:

Name of Plan
The name of this Plan is the Health Care Employees/Employer Dental and Medical Trust.

Type of Plan
The Health Care Employees/Employer Dental and Medical Trust is a collectively bargained, jointly trusteed welfare plan which provides the following benefits:

Hospital, Medical and Surgical
Dental
Life Insurance

Plan Administrator and Sponsor
The Trust is sponsored and administered by a joint Board of Trustees consisting of equal numbers of Employer Trustees and Union Trustees. The Board of Trustees has engaged Dublin Insurance Services, Inc., to perform certain routine administrative services as a contract administrator.

Address of the Trust Fund Office
Health Care Employees/Employer Dental and Medical Trust
6680 Sierra Lane
Dublin, California 94568
Telephone: (925) 803-1880
Facsimile (925) 803-8780

Plan Year
The Trust's fiscal year ends December 31

IRS Employer Identification Number
94-2356343

Plan Number
501

Funding Medium
The Health Care Employees/Employer Dental and Medical Trust is funded through employer contributions, the amount of which is specified in the collective bargaining agreement. Also, self-payments by participants are permitted as outlined on page 6.

Employer contributions are received and held in trust by the joint Board of Trustees, which pays certain premiums to the following Health Maintenance Organizations for prepaid health benefits:

Blue Shield of California
50 Beale Street, 21st Floor
San Francisco, California 94105

Fidelity Security Life Insurance
Special Insurance Services, Inc.
6509 Windcrest Drive, Suite 200
Plano, TX 75024

Health Net
155 Grand Avenue
Oakland, California 94612

Kaiser Foundation Health Plan
1800 Harrison Street, 9th Floor
Oakland, California 94612-3412

Chinese Community Health Plan
170 Columbus Avenue, Suite 210
San Francisco, California 94133

United Healthcare
2300 Clayton Road, Suite 1000
Concord, CA 94520

For dental benefits certain premiums are paid to:

Delta Dental
Delta Tower
100 First Street
San Francisco, California 94105

United HealthCare Insurance Company
22561 Network Place
Chicago, IL 60673-1225

For life insurance benefits certain premiums are paid to:

Reliance Standard Life Insurance
1850 Mt. Diablo Boulevard, Suite 510
Walnut Creek, California 94596-4472

Agent for Service of Legal Process
The Trust's agent for service of legal process is Dublin Insurance Services, Inc., 6680 Sierra Lane, Dublin, California 94568.

Collective Bargaining Agreements
The plan is maintained pursuant to various collective bargaining agreements between the California Nurses Association, SEIU United Healthcare Workers West, AFL-CIO, SEIU Local 1021 and other labor organizations representing employees in the health care industry and various employers and employer associations, or other types of written agreements between employers and the Trust. Employers make contributions to the Plan as provided in these agreements. The Administrator will provide information as to whether a particular employer or local union is participating in the Plan and the address of any participating employer or local union. All written documents and information required to be provided by law are available upon written request to the office of the Administrator.

Legal Counsel
Weinberg, Roger & Rosenfeld
1001 Marina Village Parkway, Suite 200
Alameda, CA 94501-1901

BOARD OF TRUSTEES

MANAGEMENT TRUSTEES	LABOR TRUSTEES
Glenn Berkheimer *IEDA* 2200 Powell Street, Suite 1000 Emeryville, CA 94608 Tel: 510-653-6765 / Fax: 510-658-2609	David Kramer *SEIU 1021* 417 61st Street Oakland, CA 94609 Mobile: 510-453-5471
John Nacol, CEO *Redwood Health Services* 3033 Cleveland Avenue, Suite 104 Santa Rosa, CA 95403-2179 Tel: 707-525-4370 / Fax: 707-547-4116	Hal Ruddick, Hospital Division Director *SEIU-UHW West* 560 Thomas L Berkley Way Oakland, CA 94612 Tel: 510-251-1250 / Fax: 510-763-2680
Jake O'Malley *CCC Municipal Risk Management* 1911 San Miguel Drive, Suite 200 Walnut Creek, CA 94596 Tel: 925-943-1100 / Fax: 925-946-4183	Rebecca Malberg, Home Care Division Director *SEIU-UHW West* 560 Thomas L Berkley Way Oakland, CA 94612 Tel: 510-251-1250 / Fax: 510-763-2680
Charmion Patton *Mercy Medical* 333 Mercy Avenue Merced, CA 95340 Tel: 209-564-5025	Myriam Escamilla, Nursing Home Division Director *SEIU-UHW West* 560 Thomas L Berkley Way Oakland, CA 94612 Tel: 510-251-1250 / Fax: 510-763-2680

ELIGIBILITY

Eligibility for you and your dependents (including initial eligibility, maintaining eligibility and the loss of eligibility) is determined by the collective bargaining agreement between your employer and your union, subject at all times to approval by the Board of Trustees.

Currently, the Trust offers dental benefits through Delta Dental and Pacific Union Dental and the option of one of the following HMOs: Blue Shield, Fidelity Security Life Insurance, Health Net, Kaiser Foundation Health Plan, PacifiCare, Universal Care and Chinese Community Health Plan and one PPO (Preferred Provider Organization): Blue Shield of CA. All dental and medical benefits are as described in the documents provided by the plan in which you are enrolled.

OPEN ENROLLMENT

Some employees are covered by a specific medical or dental plan only. Others, through an agreement between the Union and the Employer, may have more than one option. In these cases an annual open enrollment will be conducted through the Employer so that the employee may consider making a change of medical or dental plans. A change may only be made during an open enrollment period unless there are special circumstances, for example if the plan the employee is enrolled in is terminated. Check with your Employer or your Union for information regarding the open enrollment process.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Other special enrollment rights shall be allowed as may be required by applicable law.

Special Notice to HMO or PPO Enrollees for Medical Benefits

It is important to note that plan information provided to you by your Employer or the Trust Fund may be in summary form only and may not completely describe your benefit coverage. For details on your benefit coverage, please refer to your HMO or PPO Evidence of Coverage. The Evidence of Coverage is the binding document between the HMO or PPO and its members (or enrollees). For HMO enrollees: (1) an HMO physician must determine that the services and supplies are medically necessary to prevent, diagnose or treat your medical condition, (2) the services and supplies must be provided, prescribed, authorized or directed by an HMO physician, and (3) you must receive the services and supplies at an HMO network hospital, skilled nursing facility or medical office inside the HMO Service Area, except where specifically noted to the contrary in the HMO Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to your HMO or PPO Evidence of Coverage. If there are any discrepancies between benefits or HMO or PPO rules and regulations represented through the dissemination of information by your Employer or the Trust, and the HMO or PPO Evidence of Coverage, the HMO or PPO Evidence of Coverage will prevail.

Special Notice to Enrollees with Dental Benefits

It is important to note that plan information provided to you by your Employer or the Trust Fund may be in summary form only and may not completely describe your benefit coverage. For details on your benefit coverage, please refer to your Dental Plan Evidence of Coverage. The Evidence of Coverage is the binding document between the Dental Plan and its members (or enrollees). A Dental Plan dentist must determine that the services and supplies are medically necessary to prevent, diagnose or treat your dental condition. For details on the benefit and claims review and adjudication procedures, please refer to the Dental Plan Evidence of Coverage. If there are any discrepancies between benefits or Dental Plan rules and regulations represented through the dissemination of information by your Employer or the Trust, and the Dental Plan Evidence of Coverage, the Dental Plan Evidence of Coverage will prevail.

Plan Benefits are Payable only for Non-Occupational Illnesses and Injuries

Occupational medical expense means any medical expense, which arises out of or occurs in the course of any occupation or employment for wage or profit. No payments will be made for any injury or illness occurring in the course of employment for wages or profit or any injury or illness covered by Workers' Compensation. If a claim for occupational illness or injury is denied by the worker's compensation carrier, you should submit the claim and a copy of the denial to the Trust Fund Office for consideration.

COBRA CONTINUATION COVERAGE

Your employer is solely responsible for administering COBRA continuation coverage and will provide all legally required notices concerning such coverage. The definition for employer when used in this COBRA section only, means the employer through which COBRA coverage was elected.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you and/or your dependents lose

coverage under the Plan, you and/or your covered dependents may be eligible to continue your medical and dental benefits coverage by self-payment for a temporary period. To be eligible, a qualifying event causing the loss of coverage must take place. Life insurance benefits cannot be continued under COBRA.

COBRA Continuation Coverage may require payment of up to 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event.

Qualifying Events for Employees and Dependents
A qualifying event occurs:

1. if your employment ends (for reasons other than your gross misconduct); or
2. if your hours are substantially reduced to the point where you would not ordinarily be covered by the Plan.

In this case, you and/or your dependents may continue the coverage you had for up to 18 months following the month in which your termination or reduction in hours occurs.

There are instances when this 18-month period may be extended to 36 months. See the sections on "Second Qualifying Events for Covered Dependents" and "Disability Extension of 18-Month Period" below, as well as "Alternative Coverage".

Qualifying Events for Dependents
If one of the following qualifying events occurs, your spouse's and/or your children's coverage may be continued for up to 36 months:

1. You die while you and your dependents are covered by the plan.
2. Your divorce or legal separation prior to termination of employment (or retirement).
3. You become entitled to Medicare, if your dependents lose coverage due to this event.
4. Your child ceases to be a covered dependent.

If while on continuation coverage due to your termination or reduction in hours, your spouse and/or dependents have another qualifying event, your spouse and children may continue coverage for a total of 36 months from the date of termination. See "Second Qualifying Event for Covered Dependents" below.

Second Qualifying Events for Covered Dependents
For dependents who became covered under COBRA due to your termination or reduction in hours, the occurrence of another qualifying event, such as your divorce or legal separation, or your death, or a dependent child ceasing to be eligible as a dependent under the Plan, may extend COBRA coverage for your dependents from 18 months to a total of 36 months.

Your covered dependents must send written notice to your employer within 60 days of the occurrence of the second qualifying event and before the end of the initial 18-month period if they would like to extend their COBRA coverage. The notice must specify the name of the Plan, the name of the former employee, the type of qualifying event, the date of the qualifying event, and the names of the individuals eligible for the extension due to the qualifying event. If the employer is not informed within this 60-day period and before the end of the initial 18-month period, the right to extend COBRA coverage will be lost.

Although dependents may experience more than one qualifying event, in no case will COBRA coverage be extended to more than a total of 36 months.

Disability Extension of 18-Month Period of COBRA
If a qualified beneficiary is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act and a copy of the Social Security determination is sent to the employer, coverage may be continued for an additional 11 months for a total of 29 months. The cost for the additional 11 months is 150% of the Plan's total cost of coverage. COBRA may be continued for all qualified family members of the disabled individual.

The Social Security disability determination must be received by your employer:

1. within 60 days after the latest of:
   (a) the date of the SSA disability determination;
   (b) the date on which the qualifying event occurred;
   (c) the date on which the qualified beneficiary loses coverage; or
   (d) the date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the employer, AND
2. before the end of the original 18-month continuation coverage period.

If the determination is not received within the 60-day period as stated above and before the end of the original 18-month period, COBRA will not be extended and will automatically terminate at the end of the 18 months.

Your employer must also be informed if the qualified beneficiary is no longer considered disabled by Social Security Administration. The qualified beneficiary or a family member must notify the employer within 30 days of the date of Social Security's determination that the qualified beneficiary is no longer disabled. The extended coverage under COBRA will stop the first day of the month that begins more than 30 days after the re-determination. Make sure to check for alternative coverages or conversions that may be available to you

Notice Requirement
If your spouse or child qualifies for continuation of coverage due to a qualifying event such as divorce, legal separation or a child ceasing to meet the definition of a dependent under the plan, you must send written notice to your Employer. This notice should be given before the qualifying event or as soon as possible thereafter, but not more than 60 days after the qualifying event. The written notice must specify the name of the Plan, the name of the former employee, the type of qualifying event, the date of the qualifying event, and the names of the individuals eligible for COBRA.

If this notice is not provided to your Employer within 60 days, your dependent's right to continue under COBRA will be lost.
Once your Employer is notified of a Qualifying Event, a letter will be sent to the Employee and Qualified Beneficiaries explaining their options to continue coverage. This letter will be addressed to the Employee and Dependents at the address of record maintained by the Employer. It is the responsibility of all Qualified Beneficiaries to keep the Employer informed of their current mailing address.

If you are a covered former employee, you may add your newborn or adopted child(ren) to your continuation coverage, provided you add the child(ren) within 30 days of the birth or adoption and pay the additional premium. These children whom you add to COBRA coverage will be considered Qualified Beneficiaries under the law.

Election Requirement
You and/or your dependents must make written election on the forms provided within 60 days after the later of:

1. The date coverage would end if no continuation was elected; or
2. The date the COBRA election notice is provided.

The election form must be submitted to your Employer within the stated 60-day period; otherwise, the continuation option expires. Any Qualified Beneficiary who fails to submit the election form to continue coverage within the 60-day period will not be permitted to continue any level of coverage.

Withdrawal of Contributing Employer
You will not be able to elect COBRA continuation coverage if you lose eligibility because your employer no longer contributes to this Trust.

If you experience a Qualifying Event described under Qualifying Events, and you or your dependents elect COBRA continuation coverage then your former employer later stops contributing to this Trust, you may continue your coverage under COBRA to the end of your continuation period (i.e., 18 months, 36 months). However, if your former employer has an existing plan or establishes a new plan to cover a class of active employees formerly covered under this Trust, your COBRA continuation coverage will be terminated under this Trust since your former employer is required to provide COBRA continuation coverage for you and/or your dependents.

Automatic Coverage/Independent Rights
When the former employee chooses to continue coverage, coverage for eligible dependents will continue automatically, unless the spouse independently declines coverage. But if the former employee does not elect coverage, his/her dependents may elect COBRA coverage on his or her own. The covered employee or the covered spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Effects of Not Electing COBRA
In deciding whether or not to elect continuation coverage, you should remember that if your group health coverage is not continued, it might affect your rights under federal law as follows:

1. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of continuation coverage may help you not have such a gap.

2. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

You should also remember that you have the right to request special enrollment in another group health plan which might be available to you (such as through your spouse's employer) within 30 days after termination of your group health coverage if the loss of coverage is due to the events listed above. You will also have this same special enrollment right if you elect COBRA and continue coverage to the end of the period allowed.

You may contact your employer for additional information about these rights.

Waiver of COBRA
If you waive your right to continue coverage under COBRA and within the 60-day election period you decide that you would like to continue coverage, you may revoke that waiver as long as you send in the election form to your employer within that 60-day election period. However, your coverage will only be reinstated as of the date of your election. You will not have coverage for any claims that you may have incurred between the date of your loss of coverage due to a qualifying event and the date that you elected COBRA.

Premium Payment
The Board of Trustees may increase the COBRA premium required on a yearly basis if the cost to the Trust increases. You are responsible for making your monthly payments on a timely basis. No bills or notices will be sent by the Trust Fund or the plan administrator.

For payment to be considered timely:

Your initial premium must be received by your employer within 45 days of the date you elected COBRA. Your initial payment must cover the period from the date of loss of coverage due to the qualifying event up to the date you elected coverage.

Subsequent payments must be received by your employer by the first day of the month of coverage. If you fail to pay your premium within 30 days of the due date, your coverage will automatically terminate. You will only be provided coverage to the end of the month for which payment was received.

Once cancelled, your COBRA continuation coverage cannot be reinstated.

Termination of Continued Coverage
The continued coverage will end automatically as of the date any of the following situations occurs:

1. The date the Trust ends.
2. The date your employer, through which COBRA was elected, is no longer a Contributing Employer and has an existing plan or established a new plan to cover a class of active employees formerly covered under this Trust.
3. The required premiums are not paid on a timely basis. To be paid on a timely basis, the premium must be paid within 30 days of its due date (or within 45 days of the due date for the initial premium payment).
4. The date you become, after the date of election, entitled to Medicare or covered under any other group health plan, which does not contain any exclusion or limitation with respect to any preexisting condition.
5. The first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.
6. The date the maximum period of continued coverage has been provided, i.e., 18 or 36 months, or in the case of a disability extension, 29 months.

Notice of Unavailability of Continuation Coverage
Your employer will send written notices of the unavailability of COBRA in cases of the following:

1. If a notice is received about a qualifying event, second qualifying or disability determination and the individual is not entitled to COBRA or further continuation of COBRA;

2. If COBRA will terminate earlier than the end of the maximum period applicable to the qualifying event, i.e., for non-payment of the premium on a timely basis; the qualified beneficiary becomes entitled to Medicare or another group health plan with no pre-existing condition limitation; the qualified beneficiary is no longer disabled; or any other reason that the Plan would terminate coverage for an active employee or participant not under COBRA (such as fraud).

The notice will be sent by mail to a qualified beneficiary at the most current address on file and will include the following

information:

1. If unavailable, the reason for the unavailability of COBRA to the individual who requested continuation coverage, or why, COBRA cannot be extended;
2. If terminated earlier, the reason for the termination of COBRA if earlier than the end of the maximum period;
3. The effective date of termination; and
4. Any rights that may be available to qualified beneficiaries, such as conversion.

Conversion Privilege
At the end of the 18, 29 or 36 month continuation-of-coverage period, you may be entitled to enroll in an individual conversion plan. This plan may cost more and provide fewer benefits than your group health coverage.

EXTENDED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT

Your employer must continue to pay for your health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees,
2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months, and
3. You require leave for one of the following reasons:
   (a) Birth or placement of a child for adoption or foster care;
   (b) To care for your child, spouse or parent with a serious medical condition; or
   (c) Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the Trust cannot determine whether or not you qualify. If your employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the health plan for your coverage during the leave.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may elect continuation coverage for up to 24 months while on military leave in a manner similar to COBRA continuation coverage. If you elect continuation coverage, you may be charged no more than 102% of the full premium, except that if you are on military leave for less than 31 days, you may not be required to pay more than the normal employee share, if any, for such coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This Federal Act may affect your health coverage if you are enrolled or become eligible to enroll in a health plan that excludes coverage for preexisting medical conditions. The Health Care Employees/Employer Dental and Medical Trust does not exclude coverage for preexisting medical conditions. However, the information contained in this section is important if your coverage ends and you become eligible for coverage in another plan.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

A certificate of coverage will automatically be sent to you and your covered Dependents at your last known address if your coverage ends. If you elect COBRA continuation coverage, you will also receive a certificate after COBRA coverage ends. You and your covered Dependents may also request a certificate within 24 months of losing coverage.

If you have any questions or need a certificate of coverage, contact the Administrative Office.

COORDINATION OF BENEFITS

You or your dependents may be covered by another group health care plan. If so, Plan benefits will be coordinated to avoid duplication of payment.

Specific Conditions and How They Are Applied in Payment of Claims

1. **Active/Retired or Laid-Off Employee:** The plan covering a person as an employee who is neither laid-off nor

retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid-off or retired employee (or as that person's dependent) pays benefits second.

2. **Employee/Dependent:** The plan covering the person as an employee pays benefits first. The plan covering the person as a dependent pays benefits second.
3. **Dependent Children of Parents Not Separated or Divorced:** The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan which covered the parent longer pays first. The plan which covered the other parent for a shorter time pays second. A person's year of birth is not relevant in applying this rule.

   However, if one coordinating plan uses the birthday rule and the other uses the male/female rule, both plans will follow the male/female rule.
4. **Dependent Children of Separated or Divorced Parents:** When parents are separated or divorced, the birthday rule does not apply. Instead:
   a. The plan of the parent with custody pays first;
   b. The plan of the spouse of the parent with custody (the stepparent) pays next; and
   c. The plan of the parent without custody pays last.

   However, if the divorce decree places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.
5. **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.
6. If a person has dual coverage under the Plan because he or she is eligible and covered: (a) both as a covered employee and as a dependent of a covered employee, or (b) as the dependent of two covered employees, the total amount of benefits payable by reason of such dual coverage shall in no event exceed the amount of the expense actually incurred for which benefits are provided for such person under the Plan.

Exception to the above rules:
The Plan will pay its benefits before Medicare only for:

1. An active employee who is age 65 or older;
2. An active employee's dependent spouse who is age 65 or older;
3. The first 30 months of treatment for end-stage renal disease received by any covered person who is less than 65 years of age.

When the rules do not apply, this Plan will pay its benefits only after Medicare has paid its benefits.

With the consent of the covered person, the Fund may release to or obtain from other plans any data needed to carry out these provisions or those of other plans. Claimants too, will furnish such data to the Fund upon request. The Fund has the right to recover from other plans or persons any payments made which exceed those required by these provisions. The Fund also has the right to make direct payment to other plans or persons of amounts paid by them which should have been paid by the Fund. Such payment will be deemed benefits paid under this plan and will discharge the Fund's liability to the extent of the payment.

This order of payment can change if a court order specifically and unambiguously requires one of the parents to be financially responsible for the child's medical expense. (See Qualified Medical Child Support Orders below.)

If the plan is a "no fault" auto insurance or third party liability coverage, it is considered the primary plan.

Subrogation/Third Party Recovery
The Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act, or breach of any legal obligation on the part of that third party.

The Board of Trustees reserves the right to be reimbursed for any claim paid to a covered participant or dependent resulting from illness or injury caused by a third party, out of any recovery or any settlement received by the participant or dependent from the third party. The Board of Trustees also reserves the right to offset benefits by any amount which a participant or dependent received from a third party for covered costs for which benefits were paid under this Plan. The Board of Trustees may require, as a condition of payment for any claim hereunder, that the participant or dependent agree in writing to reimburse the Plan out of any recovery or settlement. The Board of Trustees also reserves the right to seek reimbursement from any party who may be liable for costs which were the basis of claims paid by the Plan. The Board of Trustees may assert these rights regardless of any agreement between the participant or the dependent and any third party.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Federal law provides specific rules under which group health care plans are required to provide medical benefits to a child of a participant under a state domestic relations law or state law relating to medical child support. A court or state administrative agency may issue a Qualified Medical Child Support Order (QMCSO) that requires a group health care plan to provide medical benefits to a participant's child.

The Plan will comply with any medical child support order, which is "qualified" under federal law, as determined by the administrative office or by the Board of Trustees. However, no such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of the amounts stated in the applicable description of benefits. Contact the administrative office for further details about the Plan's rules and procedures for administrating QMCSOs.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT OF 1996

Your medical HMO may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, your medical HMO may not, under Federal law, require that a provider obtain authorization from the HMO for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In conjunction with coverage for medically necessary mastectomies, your medical HMO is also required to cover:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy including lymphedemas.

Relationship Between Plan and Providers of Medical Services

No health care provider is an agent or representative of the Health Care Employees/Employer Dental and Medical Trust or of the Board of Trustees. The plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The plan makes no representation or guarantee of any kind concerning the skills or competency of any health care provider. The plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the plan. The statement also applies to all entities (and their agents, employees and representative) which contract with the plan to offer health-related services or supplies to participants and beneficiaries, including but not limited to Blue Shield, Health Net, Kaiser Foundation Health Plan, PacifiCare, Universal Care, Chinese Community Health Plan, and Delta Dental and Pacific Union Dental.

Nothing in this plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

Duration of the Plan

It is intended that the Plan will continue indefinitely, but the Board of Trustees reserves the right to change, modify, and/or discontinue the Plan at any time. In addition, this Plan may terminate by agreement of the participating employers and unions or by operation of law. If the Plan is terminated, its remaining assets, after payment of all expenses, will be used to continue to provide its benefits for as long as the Plan assets permit, or else they will be transferred to a successor plan providing health care benefits. In no event will termination of the Plan result in a reversion of any assets to the contributing employers.

CLAIMS AND APPEALS PROCEDURE

The following describes the process to appeal actions of the Administration Office with regard to the Trust's eligibility provisions or an action of the Board of Trustees. This Appeals Procedure does not apply to medical benefits obtained through the HMO in which you are enrolled nor to dental benefits obtained through Delta Dental or Pacific Union Dental.

1. No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in policies or contracts procured by the Board of Trustees or in the rules and regulations of the Board, or any right or claim to payments from the Fund, other than as specified herein.

   Any dispute as to eligibility, type, amount or duration of benefits, or any right or claim to payments from the Fund shall be resolved by the Board under and pursuant to the Plan and the Trust Agreement, except that any dispute as to type or amount of benefits which are provided pursuant to a contract of insurance or service contract entered into by the Board of Trustees shall be resolved under the terms of such contract.

   The Board shall have full discretionary authority to decide all other matters and its decision of the dispute, right or claim shall be final and binding upon all parties, No action may be brought to enforce any right under the Plan until a claim therefore has been submitted to and determined by the Board of Trustees, and thereafter the only action which may be brought is one to enforce the decision of the Board or to clarify the rights of the claimant under such decision.

2. If you are denied eligibility under the Plan, the Administration office will send a written notice of denial to you. The notice will include a description of the Plan's procedures for appeals, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

   The Board of Trustees will review the appeal at its next regularly scheduled quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed until the second scheduled quarterly meeting following the receipt of the appeal. If a decision cannot be reached at the initial or second meeting, the Trustees may defer its decision until a third quarterly scheduled appeals meeting provided a written notice is provided to the claimant.

The Board of Trustees will provide you with written notification of its decision within 5 days. The notice will include:

1. A statement describing any voluntary appeal procedures offered by the Trust and your right to obtain information about such procedures;

2. A statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

The failure to file an appeal within the 180-day period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.

STATEMENT OF ERISA RIGHTS

As a participant in the Health Care Employees/Employer Dental and Medical Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including copies of the latest annual report (Form 5500 Series) and an updated summary plan description and such other documents as may be mandated from time to time by law. The 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 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 state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may require you to pay these costs and legal fees; for example, if the court finds your claim is frivolous.

Assistance With Your Questions

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

GRANDFATHERED HEALTH PLAN NOTICE

The Board of Trustees of the HEALTH CARE EMPLOYEES/EMPLOYER DENTAL AND MEDICAL TRUST believes this plan is a "grandfathered health plan under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do no apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the number above. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dolgov/ebsa/healthreform*. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.