SEIU LOCAL 105 HEALTH AND WELFARE PLAN

PLAN AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective as of January 1, 2016, the SEIU Local 105 Health and Welfare Trust Fund (the "Fund"), which is a "Voluntary Employee Beneficiary Association" within the meaning of Section 501(c)(9) of the Internal Revenue Code of 1986 (the "Code"), as amended, adopts this amended and restated SEIU Local 105 Health and Welfare Plan (the "Plan") for the benefit of employees covered by a Collective Bargaining Agreement between Service Employees International Union Local 105 and the various employers in the Denver, Colorado region to provide health care benefits for covered, eligible employees.

The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), applicable to health and welfare benefit plans. This plan document shall serve as both the Plan and the Summary Plan Description ("SPD").

If you have any questions about the Plan, you may call or write to the Plan Administrative Manager:

Welfare & Pension Administration Services, Inc.
2815 Second Avenue, Suite 300
Seattle, WA 98124

Phone: 800-732-1121

Este cuadernillo contiene un resumen en inglés de sus derechos y beneficios conforme al Plan de Salud y Bienestar de SEIU. Si tiene dificultades para entender cualquier parte de este cuadernillo, comuníquese con Welfare & Pension Administration Services, Inc., 2815 Second Avenue, Suite 300, Seattle, WA 98124. El horario de atención es de 8:00 a.m. a 5:00 p.m., de lunes a viernes, o también puede llamarlos al 800-732-1121.

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ARTICLE 1
ELIGIBILITY AND PARTICIPATION

Section 1.1 Eligibility.

You will be notified by either the Plan Administrative Manager, on behalf of the Plan Administrator, or your Employer when you are eligible to participate in the Plan. It will be the responsibility of the Plan Administrator and the individual Employers to ensure that eligible Employees receive timely notice of their eligibility.

(a) Employee-Only Coverage. To be eligible for Employee-Only coverage, an employee must be employed by the Employer as a full-time employee for one (1) year, or, have provided 1,200 hours of service to the Employer, whichever occurs first. If the employee is a Day employee, the employee must be employed by the Employer as a full-time employee for one hundred twenty (120) days. Coverage under the Plan will begin on the first of the month which occurs 60 days after eligibility is established. After initial eligibility is established, an employee must maintain full-time status to receive coverage under the Plan.

(b) Family Coverage.

(1) Eligibility for any type of Family Coverage is determined by the Trustees of the Fund on a quarterly basis, at which time the Trustees of the Fund will evaluate the group of individuals who have become newly eligible under Section 1.1(a) above on the basis of seniority, and will determine which, if any, individuals will receive Family Coverage.

(2) A Participant receiving Family Coverage will continue to receive such coverage, regardless of his or her seniority, unless such continued coverage would be contrary to the Fund's reserve policy, as it is determined from time to time by the Board of Trustees.

(3) It is the Fund's intention to provide Family Coverage for as many individuals as possible in conjunction with the Collective Bargaining

Agreement; however, the Fund may restrict Family Coverage on the basis of seniority to certain individuals, whether such individuals are newly eligible under Section 1.1(a) above or are Participants, pursuant to the Fund's reserve policy, as it is determined from time to time by the Board of Trustees. Any seniority restrictions established under this subsection will be documented in writing. The Plan will provide you reasonable notice in the event that you are impacted by a decision of the Trustees under this subsection.

(4) In the event that the Fund has restricted Family Coverage by removing certain Participants from Family Coverage to preserve the reserves of the Fund, and in the event that the Fund later has the ability to expand Family Coverage, the Trustees of the Fund will evaluate the group of individuals who have become newly eligible under Section 1.1(a) together with those individuals previously removed from Family Coverage by the Trustees of the Fund, and not an act of their own, on the basis of seniority, and will determine which, if any, individuals will receive Family Coverage.

(c) Employee Plus Children Coverage. Effective for the Plan Year beginning January 1, 2016, an employee who is initially eligible for coverage under paragraph (a) of this Section 1.1 may elect Employee Plus Children Coverage. In addition, a Participant may elect Employee Plus Children Coverage during any Open Enrollment period or as provided in Section 1.3 with respect to any new Dependent children. Eligibility for Employee Plus Children coverage under this paragraph (c) is in addition to any eligibility that an employee or Participant may have for Family Coverage under paragraph (b), above.

In all cases, a Participant shall pay the applicable premium provided in the Collective Bargaining Agreement for Employee Plus Children coverage under this paragraph (c).

(d) Qualified Medical Child Support Order ("QMCSO"). To the extent that Plan coverage is provided in accordance with the provisions of any court

judgment, decree or order which (i) requires group health coverage for a Participant's child, and (ii) meets the requirements of ERISA Section 609(a) as a qualified medical child support order, as determined by the Plan Administrator, Plan coverage will be provided for as long as the child satisfies the definition of Dependent, and the qualified medical child support order is effective. You may not drop coverage for the Dependent unless you submit written evidence to the Administrator that the QMCSO is no longer in effect. You or your Dependent may obtain, without charge, a copy of the procedures governing QMCSO determination by the Plan by contacting the Plan Administrative Manager.

Section 1.2 Enrollment and Opt-Out

(a) Enrollment. You, and, if applicable, your Dependents, will be required to complete an enrollment form before participation in the Plan may begin. The Fund Trustees and Plan Administrative Manager will establish the enrollment procedures. You will be timely notified of the enrollment procedures, and you must comply with the procedures before your participation in the Plan may begin. Any enrollment forms utilized by the Plan Administrative Manager on behalf of the Fund will comply with the Health Insurance Portability and Accountability Act ("HIPAA") and the Genetic Information Nondiscrimination Act.

(b) Opt-Out. You may choose not to participate in the Plan (i.e., to opt-out of the Plan) if you have other health insurance. To opt-out, you must complete the appropriate form provided to you by the Plan Administrative Manager stating that you have other health insurance. Once you have opted-out, you may not enroll in the Plan for a period of one-year, unless you are eligible for the special enrollment right discussed in Section 1.3(b).

Section 1.3 Special Enrollment Rights: Change in Family Status or Loss of Other Coverage.

(a) New Dependents. You may be entitled to enroll a Dependent in the Plan under certain circumstances. If you are enrolled in Family Coverage, you must provide the Plan with written notice of any change in your family status,

such as marriage or divorce, the birth or adoption of a child, the death of a dependent, or a change in dependent status within 30 days.

Participants who are not enrolled in Family Coverage may enroll newly-acquired Dependent children by special enrollment procedures. A Dependent child, who is within the applicable age limits stated in the Dependent definition, shall become eligible on the date acquired, if enrollment for the new Dependent child is requested within thirty-one (31) days of the date of birth, adoption, or placement for adoption. Placement for adoption refers to the date the Employee or Non-Bargaining Employee has legal obligation for total or partial support in anticipation of adoption of the child.

Eligible Dependents not enrolled within the above-noted thirty-one (31) day period will be enrolled on the first (1st) day of the month following the month in which the Plan receives proper enrollment pursuant to Section 1.2.

(b) Loss of Other Coverage. In the event that you opted-out of the Plan under Section 1.2(b) above because you had other health insurance, and you later lose that health insurance due to one of the reasons listed below, you will be permitted to enroll in the Plan if you request enrollment within 30 days after the loss of the other health insurance, or within 60 days if the other health insurance was under a Medicaid plan or a State Children's Health Insurance Program ("SCHIP"). To be eligible for this special enrollment right, you must have lost your other health insurance because

i. It was COBRA continuation coverage, and you exhausted the applicable COBRA period, or

ii. It was not COBRA continuation coverage, and you lost eligibility for the other health insurance (for example, if you were receiving health insurance through your spouse, and your spouse lost eligibility for that health insurance), or any required employer contributions to the other health insurance stopped.

Regardless of the provisions above, you will not be permitted to enroll in the Plan if you lost your other health insurance because you failed to pay any premiums for the other health insurance or if you lost eligibility for the other health insurance for cause (i.e., you filed fraudulent claims).

Section 1.4 Participation.

You will begin participation in the Plan on the day you become eligible to participate.

Section 1.5 Termination of Participation.

Your participation in the Plan will terminate on the last day of the month in which employment ends, on the date you transfer into an employment position with an Employer that is not covered by a CBA, or, if you are enrolled in Family Coverage, on the first day of the first calendar year quarter immediately following a decision by the Trustees to restrict Family Coverage on a seniority basis under Section 1.1(b). However, you may be eligible for COBRA Coverage. Please see Article III.

ARTICLE 2
BENEFITS

Section 2.1 Benefits.

The Plan provides, through Employer contributions, the payment of premiums for medical and prescription insurance provided by the Insurance Company. This insurance will either be through health maintenance organizations ("HMOs") or managed care plans. A more detailed description of the insurance benefits can be found in the Evidence of Coverage issued to you by the Insurance Company, and that Evidence of Coverage is hereby incorporated into the Plan by reference, and is therefore a part of the Plan. If you misplace the Evidence of Coverage, contact the Insurance Company directly.

Benefits do not include payments for deductibles, co-payments, exclusions or limitations that may be required to be paid when you receive services or for COBRA Coverage.

Section 2.2 Pre-Existing Conditions.

The Insurance Company does not impose pre-existing condition exclusions or limitations on Participants. Therefore, if you have an illness or injury that occurs before you are a Participant, you will be eligible for future treatment of that illness or injury under the Plan as soon as you are eligible to participate. You will not be entitled to reimbursement for treatment received prior to your participation in the Plan.

Section 2.3 FMLA and Uniformed Service.

If you take a leave of absence under the FMLA or to perform Uniformed Service, your coverage under the Plan may continue. Contact the Plan Administrative Manager or the Insurance Company at the number listed on the Evidence of Coverage for additional information.

Section 2.4 Women's Health and Cancer Rights Act of 1998.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) all stages of reconstruction of the breast on which the mastectomy was performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) prostheses; and

(d) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Consult your Evidence of Coverage to determine your deductible and coinsurance. If you would like more information on WHCRA benefits, call the Insurance Company at the phone number listed in the Evidence of Coverage.

Section 2.5 Newborns and Mothers Health Protection Act.

Group health plans and health insurance issuers generally 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Section 2.6 Health Information Portability and Accountability Act ("HIPAA") and Privacy Policy.

It is the policy of the Plan to protect the privacy of information relating to your health, health care and payment for that care. This Protected Health Information ("PHI") is protected from improper use or disclosure under State and/or Federal laws, including HIPAA and Regulations promulgated thereunder by the U.S. Department of Health and Human Services ("Privacy Regulations"). The Plan has adopted policies and procedures to safeguard any PHI it receives or creates. Service providers to the Plan have entered into confidentiality

agreements concerning the use and disclosure of PHI. PHI is not released outside the Plan without your written consent, except as may be necessary for treatment, payment, Plan administration, and health care operations, including utilization review, determinations of medical necessity and appeals, research, public health and law enforcement, and other uses permitted by law or regulation. The Board of Trustees is permitted to use PHI only to the extent necessary for the Trustees to perform Plan administrative functions, including appeals, and use of summary health information to establish premium rates, obtain premium bids, and to assess, modify, amend, or terminate the Plan. For uses and disclosures of PHI that are not permitted or required by the Privacy Regulations or law, the individual's authorization must be obtained. Certain medical information will not be released without the individual's specific written permission, such as mental health records, genetic testing results, and HIV information.

Section 2.7 Your Right to Privacy.

You have the right to receive a notice describing how medical information about you may be used and disclosed, and how you can get access to this information. You also have the right to inspect and copy your own PHI and to request that your information be released to a third party or specific address by signing a written release. You also have the right to request restrictions on certain uses and disclosures of PHI. You also have the right to amend or correct your PHI, and the right to receive an accounting of certain disclosures of PHI, including Electronic Health Records. Your written permission is not required for the Plan to disclose PHI to a current care giver, such as a family member, unless you object to such disclosure. Nor is your permission required for uses and disclosures of PHI for treatment, payment, health care operations, public health purposes, law enforcement purposes, other purposes as provided by the Plan's policies and the HIPAA Privacy Regulations, or for purposes for which you have signed an authorization.

Section 2.8 Additional Governing Laws

This document may not describe all of the Federal and state laws governing your insurance benefits. Please refer to your Evidence of Coverage for further information on your insurance benefits.

ARTICLE 3
COBRA COVERAGE

Section 3.1 COBRA Coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that a group health plan must allow an individual to elect to continue health coverage, at his or her own expense, when such coverage would otherwise terminate under certain circumstances. COBRA Coverage extends existing health coverage for your eligible dependents for a limited period of time, subject to special conditions.

Nothing in this Article III will permit or operate to permit Family Coverage if you were not eligible for Family Coverage prior to the Qualifying Event.

Regardless of the COBRA coverage provisions in this Article III, COBRA coverage will be administered to comply with any Federal law or program that affects an individual's eligibility for COBRA coverage, an individual's ability to elect COBRA coverage, the applicable monthly COBRA premium, the duration of COBRA coverage, or any other aspect of COBRA coverage.

Section 3.2 Qualifying Events.

If coverage under this Plan terminates for one of the reasons set forth below, the person(s) whose coverage terminates may elect, at his or her own expense, to continue the Plan's medical and prescription drug benefits without evidence of insurability for up to 18 months for a Qualifying Event under subsection (a) or up to 36 months for a Qualifying Event under subsections (b), (c), or (d):

(a) termination as an Employee (other than for gross misconduct) or reduction of hours worked so as to render you, as a Participant, ineligible for coverage, including termination of employment following a leave under the Family and Medical Leave Act ("FMLA");

(b) the Participant's death;

(c) divorce or legal separation of the Employee from his or her Spouse;

(d) if you are a Dependent, loss of coverage due to the Participant becoming entitled to Medicare; or

(e) for a Dependent child, ceasing to qualify as an eligible Dependent.

Section 3.3 Election of COBRA Coverage.

(a) Notices. You or your Dependent must inform the Plan Administrative Manager of a Qualifying Event within 60 days of the event. The Plan Administrative Manager will then provide notice to either you or your Dependent, no later than 14 days after being notified of the Qualifying Event, of the right to COBRA Coverage and the applicable monthly premium.

(b) Election. You or your Dependent must elect COBRA Coverage within 60 days following receipt of the Plan Administrative Manager's notice of eligibility for COBRA Coverage. If you or your Dependent do not elect COBRA Coverage, the coverage under the Plan will end on the date of the Qualifying Event.

(c) Qualified Beneficiary. Once your Dependent has elected COBRA Coverage he or she is known as a "Qualified Beneficiary" under COBRA. "Qualified Beneficiary" also includes a child who is born to or placed for adoption with you, the Participant, during the period of COBRA Coverage, provided that you notify the Plan Administrative Manager in writing within 31 days of the child's birth, adoption or placement for adoption.

Section 3.4 Period of COBRA Coverage.

You and/or a Qualified Beneficiary may continue coverage for up to 18 or 36 months after the date coverage is first lost under the Plan, depending on the Qualifying Event.

(a) Extension. The maximum period described in Section 3.2 may be extended if:

(1) COBRA Coverage is triggered by a Qualifying Event in Section 3.2(a) and either you, the Participant, or the Qualified Beneficiary is found by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA Coverage, then the disabled person and his or her covered family members

will be eligible for up to 29 months of COBRA Coverage (an additional 11 months), provided that you, the Participant, would otherwise have been eligible for Family Coverage. The Administrator may assess an increased charge of up to 150% of the average total cost of individual health coverage in the geographic region for the additional 11 months of coverage; or

(2) If a Qualifying Event under Sections 3.2(b), (c) or (e) occurs within the applicable 18 or 29 month period, the period of coverage may be extended up to 36 months from the date of the first Qualifying Event for your Qualified Beneficiary Spouse and / or Qualified Beneficiary child.

To be eligible for this additional coverage, you or your Qualified Beneficiary must notify the Plan Administrative Manager in writing within 60 days of the second Qualifying Event and before the applicable 18 or 29 month period of continued coverage ends.

(b) Early Termination. The period of COBRA Coverage may be shortened for any of the following reasons:

(1) The Plan no longer provides health care coverage to any group of Participants;

(2) Failure to pay the premium within the prescribed time limits for continuing coverage; or

(3) The Qualified Beneficiary (i) becomes eligible for Medicare; or (ii) requests cancellation in writing.

Section 3.5 Premium Amount and Payment.

(a) In General. The Plan may set the monthly premium rate in an amount up to 102% of the average total cost of individual health coverage in the geographic region.

(b) Disability. If your Dependent is disabled, he or she may be required to pay up to 102% of the applicable premium for the first 18 months of coverage and 150% of the applicable monthly premium for the remaining period of coverage.

(c) Premium Due Date. You may pay the premium on a monthly basis and your first premium is due and payable *within* 45 days after you make the initial election for coverage. If there is a delay between losing Plan coverage and electing COBRA Coverage, you may be required to pay the total premiums due for the delay period in your first payment. Subsequent premium payments are due on the first day of each month. There is a 30-day grace period in which to make up a premium payment. However, COBRA Coverage will be terminated if a premium payment is not received by the Plan when due on a timely basis.

Section 3.6 Trade Adjustment Assistance Rights.

If you or a Dependent lose Plan coverage as a result of your termination of employment and you or a Dependent did not elect COBRA Coverage in connection with such loss, you or your Dependent will have a second opportunity to elect such coverage during the 60-day period that begins on the first day of the month in which you become eligible for trade adjustment assistance ("TAA") under the provisions of the Trade Act of 2002, but only if such election is made not later than six months after the date you lost coverage due to the termination of employment that entitles you to TAA. To be eligible for this second election, you or your Dependent Spouse must notify the Plan Administrative Manager in writing of such TAA eligibility within 60 days of the date you become eligible for TAA. COBRA Coverage elected in accordance with this Section 3.6 will become effective at the beginning of the 60-day election period described in Section 3.3(a).

ARTICLE 4
BENEFIT CLAIMS AND APPEAL PROCEDURES

Section 4.1 Responsibility of Claims Administrators.

The Plan Trustees have the sole and final discretion to determine an individual's eligibility for participation in the Plan. However, the Insurance Company's claim administrator has the authority to determine an individual's eligibility for medical or prescription drug benefits, including whether the expenses incurred are covered expenses and the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Insurance Company's claim administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the insurance contract as they apply to the claim.

Section 4.2 Procedures.

Your Evidence of Coverage will tell you how to obtain medical and prescription drug benefits. If a claim for benefits is denied, you have the right to appeal the denial. The appeals procedure for your insurance benefits is also outlined in your Evidence of Coverage.

Section 4.3 ERISA.

ERISA, and the regulations thereunder, will apply to all claims and appeals with the Insurance Company.

ARTICLE 5
APPEALS TO THE PLAN TRUSTEES

Section 5.1 General.

Although the Plan is administered by the Plan Administrative Manager, the Board of Trustees of the Fund is responsible for establishing rules and regulations under which the Plan operates. Interpretations of the Plan, including eligibility for participation in the Plan, and other matters relating to the operation of the Plan, are the ultimate responsibility of the Board of Trustees.

Section 5.2 Submission of a Claim.

If you or your Dependent has a claim arising under the terms of the Plan, you must submit your claim in writing to the Plan Administrative Manager.

Remember, if you have a claim or appeal regarding your eligibility for medical or prescription drug benefits under the terms of your Evidence of Coverage, including whether the expenses incurred are covered expenses under the terms of your Evidence of Coverage, you must follow the claims and appeals procedures under your Evidence of Coverage, as noted in Section 4.2. This means that, generally, the Board will only accept claims and appeals pertaining to eligibility and rescissions of coverage. The Board does not provide a two-level appeal process for any benefits.

Section 5.3 Timing of Notification of Decision.

In the case of a claim that is to be decided by the Board, you will be notified of the Board's decision on a claim made under Section 5.2 within a reasonable period of time, but no later than 30 days after receipt of the claim, or 45 days after receipt of the claim if the Board determines that such extension is necessary due to matters beyond control of the Plan. In this circumstance, the Board will, within the initial 30 day period, notify you of the special circumstances requiring an extension of time and the date by which the Board expects to make a decision. If such an extension is due to a failure to submit information that is needed to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from your receipt of the notice to provide the additional specified information.

Section 5.4 Content of Notification of Claim Denial.

The notification described in Section 5.3 will be provided in a culturally and linguistically appropriate manner and will include:

(a) Information sufficient to identify the claim involved;

(b) Upon request, and as soon as practicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(c) The specific reason(s) for the adverse decision, including the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was used in denying the claim;

(d) Reference to the specific Plan provisions on which the decision is based;

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

(f) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other criterion will be provided free of charge upon request;

(g) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established

under PHS Act Section 2793 to assist individuals with the internal claims and appeals and external review processes; and

(i) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of an appeal.

Section 5.5 Appeal of Claim Denials.

If a claim made under Section 5.2 is denied, you may appeal the denial by filing a written appeal with the Board within 180 days of receipt of notification of a denial. The following procedures will apply to the appeal:

(a) In support of the appeal, you may submit written comments, documents, records and other information relating to the claim, and the Plan will provide you upon request and at no charge with reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. Sec. 2560.503-1(m)(8)) to the claim.

(b) In reviewing the appeal, the Board will take into account all materials and information submitted by you relating to the claim (even if not submitted or considered in connection with the initial claim).

(c) The review of your appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the substitute of such individual.

(d) The Board will ensure the independence and impartiality of all persons involved in making the decision regarding your appeal.

(e) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or

other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(f) The Board will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(g) In the case of a claim involving urgent care, the Board will provide an expedited review process pursuant under which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing and all necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, fax, or other similar methods.

(h) The Board will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim and any new or additional rationale that the Plan intends to rely on in its final benefit determination. This information will be provided as soon as possible and sufficiently in advance of the Plan's final benefit determination so that you may have a reasonable opportunity to respond.

Section 5.6 Timing of Notification of Decision on Appeal.

In the case of a claim that is to be decided by the Board, the Board will make a decision no later than the date of its next meeting following receipt of the appeal, unless the request for review is filed within 30 days of that meeting, in which case, a decision will be made no later than the date of its second meeting following receipt of the appeal. Notwithstanding the foregoing, if special circumstances require a further extension of time for processing, the decision will be made no later than the date of its third meeting following

receipt of the appeal, and the Board will provide written notice of the extension to you before the commencement of the extension, describing the special circumstances and the date by which the decision will be made. The Board will notify you of its decision no later than five (5) days after the decision is made.

Section 5.7 Content of Notification of Decision on the Appeal.

The decision of the Board will be in writing, will be provided in a culturally and linguistically appropriate manner, and will include, in the case of an adverse decision:

(a) Information sufficient to identify the claim involved;

(b) Upon request, and as soon as practicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(c) The specific reason(s) for the adverse decision, including the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was used in denying the claim;

(d) Reference to the specific Plan provisions on which the decision is based;

(e) A statement that you are entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. Sec. 2560.503-1(m)(8)) to your claim;

(f) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;

(g) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination,

applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 to assist individuals with the internal claims and appeals and external review processes;

(i) A statement of your right to bring an action under section 502(a) of ERISA; and

(j) The following statement: "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."

Section 5.8 External Review.

The Board of Trustees will provide access to External Review for rescissions of coverage, as required by ERISA. The Insurance Company will provide access to External Review for claims involving medical judgment, as required by ERISA.

ARTICLE 6
AMENDMENT OR TERMINATION

Although the Plan is intended to continue indefinitely, the Board of Trustees reserves the right to change or discontinue the Plan itself, or the kinds and/or amount of benefits provided under the Plan whenever, in the exercise of its fiduciary responsibility, it appears necessary or prudent to do so. You will be timely notified in the event of any amendment or termination.

ARTICLE 7
ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

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

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 Coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Coverage, when your COBRA 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action 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 any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce these 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the 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 fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 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.

ARTICLE 8
GENERAL INFORMATION

Section 8.1 Name.

SEIU Local 105 Health and Welfare Plan

Section 8.2 Type of Plan and Administration.

The Plan is a welfare benefit plan that provides medical and prescription drug benefits through fully insured contracts with the Insurance Company.

Section 8.3 Funding.

The Plan is funded by Employer contributions made to the SEIU Local 105 Health and Welfare Trust Fund pursuant to a CBA, which are used to make premium payments to the Insurance Company, and to pay administrative expenses. The sole responsibility and liability of an Employer is to make the contributions required under the CBA on a timely basis.

Section 8.4 The Plan Sponsor, Plan Administrator, and Address:

The Plan Sponsor and the Plan Administrator are the Board of Trustees of the SEIU Local 105 Health and Welfare Trust Fund. The Board of Trustees may be reached at the address below:

The SEIU Local 105 Health and Welfare Trust Fund
Board of Trustees
c/o Welfare & Pension Administration Services, Inc.
2815 Second Avenue, Suite 300
Seattle, WA 98124

Section 8.5 Sponsor Identification Number:

27-1372825

Section 8.6 Plan Number:

501

Section 8.7 Plan Administrative Manager and Address:

Welfare & Pension Administration Services, Inc.

2815 Second Avenue, Suite 300

Seattle, WA 98124

Phone: 800-732-1121

Section 8.8 Plan Year.

The Plan's Plan Year begins January 1 and ends December 31.

Section 8.9 Service of Legal Process.

Legal process may be served on the Plan Administrator at the address above, or on a Trustee at the Plan Sponsor's address above, or at their addresses listed below.

Section 8.10 Board of Trustees.

Employer Trustees		
Bill Borger Chairman Master Klean Janitorial, Inc. P.O. Box 22044 Denver, CO 80222	Troy Coker Commercial Cleaning Systems 1485 S. Lipan St. Denver, CO 80223	Steve Larson ABM Janitorial Services 9800 E. Geddes Ave., A150 Englewood, CO 80112
Union Trustees		
Abby Kreckman Secretary SEIU Local 105 2525 W. Alameda Ave. Denver, CO 80219	Ron Ruggiero SEIU Local 105 2525 W. Alameda Ave. Denver, CO 80219	Pedro Carrillo SEIU Local 105 2525 W. Alameda Ave. Denver, CO 80219

Section 8.11 Powers and Authority of Plan Administrator

The Plan Administrator, which is the Board of Trustees, has the full power to administer the Plan in all of its details, subject to applicable requirements of law. The Plan Administrator's powers will include, but will not be limited to, unilateral discretion to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan, to allocate and delegate its responsibilities under the Plan, and to designate other persons from time to time to carry out any of its responsibilities under the Plan, provided that any allocation, delegation, or designation is in writing.

Section 8.12 Collective Bargaining Agreement and Employer Sponsors.

The Plan is maintained pursuant to one or more CBAs. You may obtain copies of the CBAs upon written request to the Plan Administrator; such copies are available within 30 calendar days after written request is received. Copies of the CBAs are also available from an Employer or Local 105. You or your Dependents may also receive a complete list of the employers and employee organizations sponsoring the Plan upon written request to the Plan Administrator. Finally, you or your Dependents may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan, and, if the employer or employee organization is a Plan sponsor, its address.

Section 8.13 Not a Contract.

This Summary Plan Description is not a contract and nothing contained herein should be construed to provide any rights not otherwise specifically mentioned. The Board of Trustees maintains the right to alter, modify or terminate the Plan and its benefits in any manner which they determine to be consistent with their fiduciary obligations under ERISA.

Section 8.14 Trust Agreement Controls.

The provisions of this Summary Plan Description are subject to and controlled by the provisions of the Agreement and Declaration of Trust establishing the Fund. In the event of any conflict between the provisions of this Summary Plan Description and the provisions of the Agreement and Declaration of Trust, the provisions of the Agreement and Declaration of Trust shall control.

Section 8.15 Disclaimer.

Other than benefits which are expressly provided pursuant to an insurance contract, the benefits provided by this Plan are not insured. There is no obligation or liability on the Plan, the Board of Trustees, or any other individual or entity to provide payment over and beyond the amounts in the Plan collected and available for such purpose, and then only to the extent specifically provided in this Summary Plan Description, as amended, interpreted, and construed by the Board of Trustees.

Section 8.16 No Vested Rights.

No Plan Member, dependent, beneficiary, individual, or other person or entity shall have any right to any benefit provided by the Plan.

Section 8.17 Construction of Terms.

The Plan Board of Trustees shall have the complete discretion, right and authority to interpret, construe, and apply any and all terms or provisions of this Summary Plan Description, the Trust Agreement, and any other document pursuant to which the Plan is maintained or benefits are paid, whether or not such terms or provisions are considered vague, ambiguous, or unclear. The Board of Trustees shall have the authority, right and discretion to make any and all findings of fact or other determinations which are necessary or appropriate to any eligibility determination, benefit determination appeal, or application of the Trust Agreement, the Summary Plan Description, or other documents of the Plan. The Board of Trustees' interpretation, construction, and application of terms and provisions, as well as its findings and determinations shall be final and binding with respect to all Plan Members, dependents, and beneficiaries, any party claiming under or on behalf of any Participant, and any other interested individuals or entities.

ARTICLE 9
DEFINITIONS

The following terms will have the meanings set forth below, unless a contrary meaning is clearly intended by the context in which they are written.

Section 9.1 "Board of Trustees" or "Trustees" means the Trustees of the SEIU Local 105 Health and Welfare Trust Fund.

Section 9.2 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Section 9.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time, and regulations issued thereunder.

Section 9.4 "Collective Bargaining Agreement" or "CBA" means a contract between Local 105 and a building maintenance and janitorial employer in the Denver, Colorado region that provides health benefits to its employees covering Employees which is in effect as of February 15, 2010, as well as any future contracts which expressly require the Employer to make contributions to the Fund for health care benefits.

Section 9.5 "Day employee" means an employee that commences work between 4:00 a.m. and 2:00 p.m.

Section 9.6 "Dependent" means the following individuals:

(a) Your Spouse;

(b) Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age specified in the "Summary Chart" contained in the Evidence of Coverage;

(c) Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:

(1) they are under the dependent limiting age specified in the "Summary Chart" contained in the Evidence of Coverage, and

(2) you or your Spouse is the court-appointed permanent legal guardian (or was the person's court-appointed permanent legal guardian before the person reached age 18);

(d) Your or your Spouse's unmarried children over the dependent limiting age specified in the "Summary Chart" contained in the Evidence of Coverage who are medically certified as disabled and dependent upon you or your Spouse, who are in fact dependent on you or your Spouse, provided that you, the Participant, provide proof of the person's disability and dependency in accordance with the Insurance Company's requirements; or

(e) If applicable, an individual who is determined to be an alternate recipient of a Participant under a qualified medical child support order (a "QMCSO").

Section 9.7 "Effective Date" means January 1, 2016. The Plan was originally effective as of February 15, 2010.

Section 9.8 "Electronic Health Record" means an electronic record that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

Section 9.9 "Employee" means an employee who is employed by an Employer who qualifies for coverage under the Medical Plan.

Section 9.10 "Employee-Only Coverage" means group health plan coverage for an individual Employee only.

Section 9.11 "Employee Plus Spouse Coverage" means group health plan coverage for an individual Employee and his or her Spouse.

Section 9.12 "Employee Plus Children Coverage" means group health plan coverage for an individual Employee and his or her children.

Section 9.13 "Employee Plus Family Coverage" means group health plan coverage for an individual Employee, his or her Spouse, and his or her children.

Section 9.14 "Employer" means an employer who has executed and/or is bound to the Collective Bargaining Agreement.

Section 9.15 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 9.16 "Evidence of Coverage" or "Certificate of Coverage" means the document issued to you by the Insurance Company that contains a description of the insurance benefits available to you.

Section 9.17 "FMLA" means the Family and Medical Leave Act.

Section 9.18 "Family Coverage" means, collectively, Employee Plus Spouse Coverage, Employee Plus Children Coverage, and Employee Plus Family Coverage.

Section 9.19 "Fund" means the SEIU Local 105 Health and Welfare Trust Fund.

Section 9.20 "HIPAA" means the Health Insurance Portability and Accountability Act as amended by the Health Information Technology for Economic and Clinical Health Act.

Section 9.21 "Insurance Company" means the insurance company or provider chosen by the Fund from time to time, under a contract to provide group health insurance benefits to Participants.

Section 9.22 "Local 105" means Local Union 105 affiliated with the Service Employee International Union, AFL-CIO, CLC.

Section 9.23 "Participant" means (a) a current Employee who participates in the Plan, or (b) a former Employee who is covered by the Plan or is eligible to participate in the Plan.

Section 9.24 "Plan" means the SEIU Local 105 Health and Welfare Plan established by this document.

Section 9.25 "Plan Administrator" means the Board of Trustees of the SEIU Local 105 Health and Welfare Trust Fund. The Plan Administrator will be the "named fiduciary" of the Plan, within the meaning of ERISA Section 402(a).

Section 9.26 "Plan Administrative Manager" means the entity or individual designated from time to time by the Board of Trustees to supervise the administration of the Plan

Section 9.27 "Plan Sponsor" means the SEIU Local 105 Health and Welfare Trust Fund.

Section 9.28 "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (2) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (3) is received or created by on behalf of the Plan. PHI also includes Genetic Information, as defined in Section 2971 of the Public Health Service Act, as amended by the Genetic Information Nondiscrimination Act of 2008.

Section 9.29 "Qualified Beneficiary" is defined in Plan Section 3.3(c).

Section 9.30 "Qualifying Event" is defined in Plan Section 3.2.

Section 9.31 "Spouse" means an individual who is recognized as the lawful husband or lawful wife of a Participant under Federal and Colorado law, including common law spouses under such laws.

Section 9.32 "Uniformed Service" means the performance of duty on a voluntary or involuntary basis under competent authority, and includes active duty, inactive duty for training, initial active duty for training, full-time National Guard duty, and a period during which an Employee is absent from employment with an Employer for the purpose of an examination to determine the fitness of the Employee to perform any such duty in the United States Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or full-time National Guard duty), the commissioned corps of the Public Health Service and any other category of person designated by the President of the United States in time of war or emergency.

Section 9.33 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 9.34 "WHCRA" means the Women's Health and Cancer Rights Act of 1998.