

**Summary Plan Description For  
Healthcare Benefits Trust Health and Welfare  
Plan**

**Effective Date: January 1, 2022**

## **1. Introduction**

This Healthcare Benefits Plan (the “Plan”) is sponsored by the Trustees of the Healthcare Benefits Trust (the “Trust”), all of whom are members of the Texas Freelance Association (the “Association”). The Trust was initially formed by the Trustees and the Association in order to provide health and welfare benefits to the Association’s eligible members and their dependents. The members of the Association who participate in the Trust and the Plan act as the “employer” (as that term is defined in Section 3(5) of the Employee Retirement Income Security Act of 1974 (“ERISA”)) with respect to the Plan. The Plan is a bona fide employer association “employee welfare benefit plan” and “group health plan” under ERISA.

The Trust will provide the Benefits for Covered Health Services set forth in the Plan, as described in the attached *2022 Member Plan Document for Plans offered under the Healthcare Benefits Trust*, subject to the terms, conditions, exclusions, and limitations of the Plan. This summary document, when attached to your Member Plan Document, together constitutes your Summary Plan Description (“SPD”).

## **2. General Information about the Plan**

### **Plan Name**

The name of the Plan is the Healthcare Benefits Trust Health and Welfare Plan.

### **Type of Plan**

The Plan is an employee welfare benefit plan that is subject to the provisions of ERISA.

### **Plan Year**

The plan year is January 1 – December 31.

### **Plan Number**

The plan number is 501.

### **Effective Date**

The effective date of the Plan is January 1, 2022.

### **Grandfathered Status**

The Plan is not a “grandfathered plan” under Section 1251 of the Affordable Care Act.

## **Funding Medium and Type of Plan Administration**

The Plan is “self-insured,” which means benefits are paid from the assets held in the Trust and are not guaranteed by an insurance company. The Trust has contracted with Decent, Inc. (“Decent”) to serve as the third-party Claims Administrator. Decent will process claims, manage the network of providers, and answer medical benefit and claim questions. Contact information for the Claims Administrator appears below under the heading “Claims Administrator and Fiduciary.”

## **Plan Sponsor**

The Trustees of the Healthcare Benefits Trust  
1401 Lavaca St. #570  
Austin, TX 78701

## **Plan Sponsor’s Employer Identification Number**

The Trust’s employer identification number (EIN) is 85-6733710.

## **Trustees**

Marc Nathan  
7108 Villa Maria Lane  
Austin, Texas 78759

Jenny Magic  
7712 Lazy Ln  
Austin, TX 78757

## **Plan Administrator**

The Trustees of the Healthcare Benefits Trust  
1401 Lavaca St. #570  
Austin, TX 78701

## **Claims Administrator and Fiduciary**

Decent is the Plan’s Claims Administrator and Claim’s Fiduciary. The role of the Claims Administrator is to handle the date-to-day administration of the Plan’s coverage, as directed by the Plan Administrator, through an administrative agreement with the Trust. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan and shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

You may contact the Claims Administrator by phone toll-free at (866) 432-7887, by visiting [www.decent.com](http://www.decent.com) or in writing at:

Decent, Inc. dba Decent TPA  
P.O. Box 4366  
Seattle, WA 98194-0366

**Agent for Service of Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's agent for service of legal process is:

Decent, Inc. dba Decent TPA  
P.O. Box 4366  
Seattle, WA 98194-0366

Service of process may also be made upon any trustee of the Plan.

## **Notice Regarding Designation of Primary Care Providers**

The Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan's Network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For more information on the requirement to designate a primary care provider, please refer to the attached Member Plan Document. For more information on how to select a primary care provider, and for a list of the participating primary care providers and providers who specialize in obstetrics or gynecology, contact Decent toll-free at (866) 432-7887, by visiting [www.decent.com](http://www.decent.com), or at the address listed above.

## **Important Disclaimer**

This SPD only summarizes the provisions of the formal Plan document and does not attempt to cover all of the details contained in the Plan document. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official Plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official Plan document, the provisions set forth in the Plan document will govern in all cases. If you wish to review the Plan document, please refer to the attached Member Plan Document or request a copy from the Plan Administrator.

## **3. Eligibility and Participation Requirements**

### **Eligibility**

To determine whether you and your spouse and/or dependents are eligible to participate in the Plan, please read the information contained in Member Plan Document attached to this SPD.

### **Need For Enrollment**

You must affirmatively enroll to receive benefits under the Plan. Eligible Association Members must complete an application form to enroll themselves and/or their eligible spouses and dependents.

### **When Participation Begins and Ends**

For information about when coverage begins and ends, please read the eligibility and participation information contained in the Member Plan Document Attached to this SPD.

#### **4. Summary of Plan Benefits**

##### **Available Benefits**

The Plan makes certain health benefits available to eligible employees and working owners of Association Members eligible to participate in the Trust and their eligible spouses and dependents. A summary of the benefits provided under the Plan is set forth in the attached Member Plan Document. Your Member Plan Document describes the types of benefits, scope of coverage, prerequisites to being covered, and other details regarding your benefits. As noted above, you must read the booklet to understand your benefits.

##### **Qualified Medical Child Support Orders**

The Plan extends benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA section 609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

#### **5. Circumstances That May Affect Benefits**

Your ability to obtain benefits and have health care expenses paid ends when your coverage ends, which can occur for a number of reasons. Depending on the reason coverage was terminated, you may have the right to continue coverage temporarily under COBRA, a state continuation law or Federal law protecting members of the uniformed services (USERRA).

The Plan may recover overpaid benefits and erroneously paid benefits through its rights to subrogation, reimbursement and offset. These rights are described in the attached Member Plan Document.

## **6. How the Plan is Administered**

### **Plan Operations**

The Plan is administered by both the Trustees of the Trust and one or more third-party administrators, including Decent.

### **Plan Administration**

The Trustees of the Trust serve as the Plan Administrator. As the Plan Administrator, the Trustees are responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, filing an annual report with the federal government).

### **Discretionary Authority of Plan Administrator and Claims Fiduciary**

The Plan Administrator and other Plan Fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan, which includes the attached Member Plan Document. Any interpretation or determination made under this discretionary authority shall be afforded deference and be legally binding on all parties subject to review by a legal authority only to the extent the decision was arbitrary and capricious. Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with, and consent to, any decisions that the Plan Administrator or other Plan Fiduciaries make, in their sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

### **Determining Eligibility to Participate**

The Plan Administrator is responsible for determining whether a particular individual is eligible to participate in the Plan.

### **Your Questions**

If you have any general eligibility questions regarding the Plan, please contact the Plan Administrator.

If you have questions regarding eligibility for a benefit and/or the amount of any benefit payable under the Plan, please contact Decent.

## **7. Amendment or Termination of the Plan**

The Trustees of the Trust, as the Plan Sponsor, have the right to amend or terminate the Plan at any time.

## **8. No Contract of Employment**

### **No Contract of Employment**

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and your employer or the Trustees of the Trust, to the effect that you will be employed for any specific period of time.

## **9. Claims Procedures**

### **Benefit Claim**

Decent is responsible for evaluating all benefit claims under the Plan. Decent will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. For a description of the Plan's claim procedures, please refer to the attached Member Plan Document.

### **Appealing A Denied Claim**

If your claim is denied (that is, not paid in part or in full), you will be notified and you may appeal to Decent for a review of the denied claim. Decent will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. For a description of the Plan's claim appeals procedures, please refer to the attached Member Plan Document.

### **Important Appeal Deadlines**

If you do not appeal on time, you may lose your right to file suit in a state or federal court, as you may not have exhausted your internal administrative appeal rights (which is generally a condition for bringing suit in court.)

### **Claims Limitations Period**

If you wish to seek judicial review of an adverse benefit determination under the Plan, whether in whole or in part, you must file any suit or legal action, including, without limitation, a civil action under Section 502(a) of ERISA, within one year of the date the final decision on the adverse benefit determination on review is issued or should have been issued under the terms of the Member Plan Document or you will lose any rights to bring such an action.

### **Other Exclusions on Benefits**

Other circumstances that may affect your benefits are described in your Member Plan Document. It is important that you read your Member Plan Document carefully.

### **Administrative Requirements and Timelines**



Your Member Plan Document also contains information about other reasons your claim may not be paid. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit claims within that time period may result in a denial.

### **External Review**

Under certain circumstances, you may have the right to obtain external review (that is, review outside of the Plan). The attached Member Plan Document provides additional detail regarding this right to external review.

### **See Member Plan Document For More Information on Claims Procedures**

The attached Member Plan Document has additional information on claims for benefits, appeals, exclusions, timelines and your right to external review.

## **10. Statement of ERISA Rights**

As a participant in the Plan, 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**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts 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 copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for 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 (SAR).

### **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.

### **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 the 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 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 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 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 is frivolous.

### **Assistance with Your Questions**

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

### **Attachments**

(1) *2022 Member Plan Document for Plans offered under the Healthcare Benefits Trust*