SUMMARY PLAN DESCRIPTION

for the

MEDICAL EXPENSE REIMBURSEMENT PLAN

of the

PORAC RETIREE MEDICAL TRUST

Based on Plan effective January 1, 2022
(as amended by Am. Nos. 1-21).

Also includes:
COBRA General Notice;
HIPAA Notice of Privacy Practices

11/12/21 dr.

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PORAC RETIREE MEDICAL TRUST

Dear Participants of the PORAC Retiree Medical Trust:

The Peace Officers Research Association of California ("PORAC") established the PORAC Retiree Medical Trust (the "Trust") to provide additional financial support to participating PORAC members during retirement. This Summary Plan Description is important for anyone whose Association has negotiated for contributions to the Trust in its MOU. By contributing to the Trust, you are pre-funding for payment of medical expenses in retirement.

The Trust is a highly tax-favored vehicle to help retirees meet the rising cost of health care. Your contributions to the Trust are not taxable income to you, and the benefit payments you will receive from the Trust during retirement will not be taxed (unlike pension benefit payments to you, which are taxed). Further, the Trust uses investment professionals to invest your contributions, and there is no tax on the earnings.

We, the Board of Trustees, are fellow peace officers, selected by the members and leadership of PORAC. We are pleased to distribute this Summary Plan Description, which is an explanation of your benefits and rights under the Medical Expense Reimbursement Plan (the "Plan"), presented in a Question-and-Answer format.

PORAC has worked diligently to establish and support this Plan, in hopes of helping PORAC members and their families to lessen the burden of retiree medical costs. We welcome your input and comments.

Best regards,

Terry A. Moore (*ret.)*, Chico Police Officers' Association
Chairman, Board of Trustees
PORAC Retiree Medical Trust

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HIGHLIGHTS OF THE PLAN

- **Benefits**. Your benefits from this Trust come in the form of reimbursement for certain medical costs, which are called "Covered Expenses,"[1] incurred after you retire. There are different levels of benefit payments, depending on how long you were in the Plan.
- **Changes of Employment Status, Address, Spouse or Child(ren)**. Please notify the Trust Office of changes to your employment status or any significant life event that you think might affect your participation in the Trust. For example, if you retire or otherwise separate from employment, you might be entitled to begin receiving benefits, or to make self-pay contributions under COBRA. If there is a change in mailing address or family composition (i.e., marriage, divorce, or birth of a child), <u>failure to notify the Trust Office may result in loss or delay of benefit payments.</u>
- **Claims**. You must present your claims to the Trust Office with your proof of payment of Covered Expenses, on a form approved by the Trustees, by September 30, i.e., within three months after the end of the plan year (which runs from July 1 – June 30). In other words, <u>submit your claims by September 30 for expenses incurred in the previous plan year.</u>
- **Funding.** The Trust is funded by mandatory employee/employer contributions and transfers of accrued leave, as set forth in your Association's Memorandum of Understanding. There is no individual election to contribute to the Trust. For more information on funding requirements to join the Trust, please contact the Trust Office.
- **Trust Office**. The Trust Office provides important services to Trust participants. For example, to find out your benefit level, submit benefit claims, request a copy of the Plan or notify the Trust of a change in address, you need to contact the Trust Office. You may contact the Trust Office at:

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: 877.808.5994 Fax: 866.676.1530
E-mail: PORAC@vimly.com
Website: **PORACRMT.org**

<u>IMPORTANT NOTE</u>: The questions and answers in this Summary Plan Description ("SPD") have been designed to provide you with key information about the PORAC Retiree Medical Trust, but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Medical Expense Reimbursement Plan of the PORAC Retire Medical Trust," effective October 1, 2018, as amended (the "Plan"). If there is a conflict between what is contained in the Plan and what is contained in the SPD or any other descriptions, the terms of the Plan will prevail.

[1] Capitalized terms contained herein are defined in the formal Plan document, and many are described in the Summary Plan Description. You may view the Plan on the Trust's website, which is PORACRMT.org. You may also request a copy of the Plan by contacting the Trust Office.

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PART 1
PARTICIPATION

- **Who can participate in the PORAC Retiree Medical Trust?**

Eligibility in the Retiree Medical Trust is generally open to all permanent Employees who are members of a bargaining unit represented by a PORAC member association, if that Association has agreed in its Memorandum of Understanding ("MOU") to participate in the Medical Expense Reimbursement Plan. Contributions must be made to the Plan, as required by the Association's MOU, on behalf of the Employees.

- **Which of my family members are Beneficiaries of the Plan?**

Beneficiaries include your lawful spouse (either opposite sex or same sex), the Children of the Eligible Retiree; and the Surviving Spouse and Surviving Children of the Eligible Retiree. The Plan covers Children and Surviving Children (biological, adopted, and stepchildren) of the Eligible Retiree up to their 26th birthday. Disabled dependent children are covered regardless of age, for so long as the child is determined to be totally disabled by the Social Security Administration. The spouse or Child of an Employee who has satisfied all the eligibility requirements, except that the Employee dies prior to separating from service, shall also be considered a Surviving Spouse or Surviving Child.

PART 2
BRIEF DESCRIPTION OF PLAN BENEFITS

- **What are the two categories of Beneficiaries?**

The Plan provides for two categories of Beneficiaries: "Regular Beneficiaries" and "Account Beneficiaries." It is possible to belong in one or both of these categories.

A "Regular Beneficiary" is entitled to monthly benefit payments for life[2] up to a certain monthly benefit level, for reimbursement of medical expenses, because he/she met the eligibility requirements listed in Part 3 hereof.

An "Account Beneficiary" is entitled to reimbursement of miscellaneous amounts from his/her Individual Account as needed, up to the balance in the Individual Account. These reimbursements may not last for life if the Individual Account is exhausted. An Eligible Retiree will have an Individual Account if one of the circumstances listed in Part 4 hereof applies to him or her.

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[2] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify, limit, or terminate benefits as necessary to preserve the financial soundness of the Plan.

- **What forms of benefit payments does the Trust provide?**

The Trust provides two forms of benefit payments: 1) regular, monthly reimbursement payment up to your benefit level (assuming you have reimbursable expenses); and 2) Individual Account benefit payments, which are capped only by the Individual Account balance and payable whenever you submit the claim for a Covered Expense (may not be monthly). You might qualify for both types of benefits (see Parts 3 and 4 hereof for more details). They both reimburse you for out-of-pocket medical expenses or insurance premiums after you retire.

The Trust will reimburse Eligible Retirees for properly and timely submitted claims on the following terms:

❖ A "Regular Beneficiary" is entitled to monthly reimbursement of Covered Expenses up to the amount of his/her individual monthly benefit level. Part 3 herein describes how to determine your benefit level.

❖ An "Account Beneficiary" is entitled to reimbursement of Covered Expenses in an amount up to the balance in his/her Individual Account. Part 4 herein describes how your Individual Account balance is calculated.

<u>Cost Sharing.</u> It is important to remember that your monthly benefit level or Individual Account balance may not cover the entire Covered Expense amount. If your benefit level does not cover the entire cost of your Covered Expense, you will be responsible for the remainder.

- **What medical expenses will be reimbursed by the Plan?**

The following medical expenses are considered "Covered Expenses" and will be reimbursed by the Plan:

❖ Premium payments for coverage under health, dental, or vision insurance plans.

❖ Medical expenses that are excludable from gross income under Internal Revenue Code Section 213(d), in other words, costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs.

❖ Premium payment for qualified long-term care (LTC) insurance.

See Plan Section 1.9 for a full definition of "Covered Expenses." You can also refer to IRS Publication 502 for a detailed description of tax deductible medical expenses at http://www.irs.gov/pub/irs-pdf/p502.pdf. Any medical expense approved by the IRS for deduction is payable by this Plan.

An Eligible Retiree can also submit claims for Covered Expenses of his/her Beneficiaries, i.e., legal spouse and Children. However, the monthly benefit level is shared amongst all Beneficiaries; the benefit level is not increased if the Eligible Retiree submits a claim for his/her spouse or Child. For example, if the Eligible Retiree's monthly benefit level is $200, then the Eligible Retiree can submit a claim for the Covered Expenses of all Beneficiaries up to a total reimbursement of $200 for that month.

Note re Christian sharing ministries. Please note that the IRS may not allow a tax deduction for contributions to cost-sharing ministries, such as the Christian Healthcare Ministries. It will depend on several factors. Accordingly, such contributions may not qualify as a Covered Expense under this Plan. Please check with the Trust Office for the latest status under IRS rules.

PART 3
MONTHLY BENEFITS

- **In what circumstances will I receive regular monthly benefits?**

If you become a Regular Beneficiary of the Trust, you will be entitled to a lifetime stream[3] of monthly benefit payments, for reimbursement of medical expenses, at your individual monthly benefit level. See Plan Sections 3.2 – 3.3 for details.

- **How do I become a "Regular Beneficiary," eligible for monthly benefits?**

An Eligible Retiree generally becomes a "Regular Beneficiary" entitled to monthly benefits after meeting all of the following requirements:

❖ He/she earns ten years of Active Service (or five years of Active Service if the person is already an Employee when his/her Association joins the Trust);

❖ Ten years have passed since the commencement of Contributions (or five years, if the five-year rule stated above applies);

❖ Contributions are made to the Trust on his/her behalf for all years of Active Service;

❖ He/she attains age 55; and

[3] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify, limit, or terminate benefits as necessary to preserve the financial soundness of the Plan.

- ❖ He/she ceases all employment (including part-time and contract work) with all participating employers in the Trust.

- **How do I earn Active Service?**

An Employee may earn Active Service in the following ways.

- ❖ Contributions to the Trust. Generally, you will receive years of Active Service credit for all periods of full-time employment during which your employer makes contributions to the Trust on your behalf.

- ❖ Contribution after Termination or Reduction of Employment (your "COBRA" right under federal law). If your employment is terminated (except for gross misconduct) or reduced to less than full-time, you may continue to earn Active Service for a maximum of eighteen months, by making periodic self-payments to the Trust as permitted by the federal law known as COBRA,[4] and subject to rules set by the Trustees. You may be able to attain eligibility for monthly benefit payments as a Regular Beneficiary by making COBRA payments after termination, including after retirement, depending upon how many months of Active Service you need for eligibility.

- **What is the difference between "Active Service" and "Active Service Units" (or ASUs)?**

- ❖ "Active Service" reflects periods of employment when your employer transfers contributions to the Trust on your behalf. Your length of Active Service is one of the factors that determine your eligibility for monthly benefits as an Eligible Retiree.

- ❖ "Active Service Units" reflect the number of $50 contributions made on your behalf to the Trust. The number of Active Service Units ("ASUs") is a factor in determining your benefit level.

- **Will I qualify for monthly benefits as a Regular Beneficiary if I leave my job before I have earned 10 years of Active Service (or 5 years, if I was in the Association when it joined the Trust)?**

No. An Employee who does not meet the minimum Active Service requirement will generally not qualify for lifetime[5] monthly benefits as a Regular Beneficiary. However, such an Employee is eligible for certain benefits from his/her Individual Account. (See Part 4 herein for more information on Individual Account benefits.)

[4] The Consolidated Omnibus Budget Reconciliation Act of 1986.

[5] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify, limit, or terminate benefits as necessary to preserve the financial soundness of the Plan

Please note that, under federal COBRA law, you can self-pay up to 18 months of contributions following termination of employment in order to attain the minimum five years of Active Service for eligibility. And even if you have five years of Active Service, you can also self-pay up to 18 months of contributions to increase your ASUs, which will increase your benefit level, following termination of employment. See the COBRA General Notice (attached) for a more detailed description of your right to self-pay contributions under COBRA

- **How is my monthly benefit level calculated, if I am a Regular Beneficiary?**

A Regular Beneficiary's monthly benefit level is determined by multiplying the number of "Active Service Units" he/she had earned up to retirement by the "Unit Multiplier" in effect when he/she stopped making contributions. Note that:

❖ An Employee earns Active Service Units during each month of contributions to the Trust. Each monthly contribution of $50 earns the Employee one Active Service Unit.

❖ An Employee may also earn Active Service Units by electing to convert sick/vacation leave transfers into Active Service Units, at actuarial cost, which is based on the actual age of the Employee at the date of transfer. This election to convert sick/vacation leave transfers can be on an annual basis or at retirement. See Section 2.2(c) of the Plan. To find out the actuarial cost of your leave conversion, please refer to Appendix C at the back of this SPD, "Leave Conversion Tables."

❖ The Unit Multiplier is a factor determined by the Trustees, with actuarial advice. Currently, the Unit Multiplier is $.74. (You may contact the Trust Office to find out if the current Unit Multiplier has changed from the one stated here.)

(See Appendix B at the end of this SPD for examples of benefit level calculations.)

- **Is it possible for my monthly benefit level to change after I start benefits?**

Yes, it is possible for your benefit level to change; benefits under the Plan are not vested. The Trustees reserve the right and power to adjust the Unit Multiplier or other Plan terms. Such adjustments may apply to current as well as future Beneficiaries.

- **Why is my monthly benefit level different from the benefit level of other Eligible Retirees in my Association and other participating Associations?**

A Regular Beneficiary's monthly benefit level is dependent on how long his/her Association participated in the Trust, the contribution level negotiated in the MOU, the Beneficiary's period of Active Service when he/she was an employee, and whether the Beneficiary converted leave to ASUs. Thus, the individual monthly benefit level will

differ among Plan participants, even within the same Association.

The number of Active Service Units ("ASUs") that an Employee earns during his/her career will affect the monthly benefit level for which he/she will be entitled as a Regular Beneficiary. That number of ASUs is determined by the monthly contribution rate negotiated by the Employee's bargaining unit and the number of months that you work after the start of contributions. So, the longer your employer makes contributions and the higher those contributions, the higher your monthly benefit level will be. For example, a monthly contribution rate of $300 will provide to each employee in that bargaining unit six Active Service Units per month, whereas a monthly contribution rate of $400 will earn eight Active Service Units per month. Likewise, if you work for 20 years and receive contributions every month, your benefit level will be higher than an employee who works for only 10 years and receives the same monthly contribution each month

PART 4
INDIVIDUAL ACCOUNT BENEFITS

- **What benefits are provided to Account Beneficiaries?**

An Account Beneficiary is entitled to reimbursement of Covered Expenses in any amount, up to the balance of his/her Individual Account. There is no monthly limit on Individual Account benefits. Proper claims will generally be reimbursed until the Individual Account balance falls to zero. See Plan Section 3.5 for details.

- **How do I become eligible for Individual Account benefits?**

An Eligible Retiree will become an Account Beneficiary if one of the following circumstances applies to him/her:

❖ Monthly payroll contributions were made to the Trust on his/her behalf, but he/she did not meet the Active Service requirement to become a Regular Beneficiary. Therefore, the contributions are credited to his/her Individual Account.

❖ The employer transferred sick and/or vacation leave to the Trust on his/her behalf, and the retiree did not elect to convert all of the leave transfer to Active Service Units.

- **How is the balance of my Individual Account calculated?**

The balance of an Individual Account will be determined by the sum of the following:

❖ Credit for the amount of any mandatory transfers of sick and/or vacation leave made on the Employee's behalf;

❖ Credit or debit for investment earnings (i.e., net of investment gains/losses and fees);

❖ Credit for any mandatory payroll contributions transferred to the Individual Account upon separation from employment for an Employee who does not meet the minimum Active Service requirement of ten years (or five years, if applicable) to qualify for monthly benefits;

❖ Debit for any benefit payments; and

❖ Debit for reasonable administrative expenses.

Important Note: See Part 5 of this SPD regarding a possible forfeiture of your Individual Account.

- **How does the Trust invest the funds that are credited to my Individual Account?**

You can choose from three investment options in which to invest the funds credited to your Individual Account. You can make an initial investment selection when contributions are first credited to your Individual Account, and you may change your selection annually in June. For details, request an Individual Account Portfolio Investment Selection Packet from the Trust Office.

PART 5
LOSS, DENIAL, FORFEITURE OR DELAY OF BENEFITS

- **What circumstances may result in my ineligibility or denial of benefits? Recoupment of overpaid benefits.**

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include: failure by the Employee or employer to make required contributions, failure to properly submit expense receipts, failure to meet the eligibility requirements, death of the Beneficiary, or termination of the Plan.
The following events will result in automatic termination of benefits:

❖ An Eligible Retiree's benefits under this Plan will terminate upon his/her death, or if he/she returns to employment with a Participating Employer.

❖ A Surviving Spouse's benefits under this Plan will terminate after 24 months of benefits have been paid after the Eligible Retiree's death. However, these benefits will resume in the month the Spouse attains the Employee's eligibility age under the Plan, and will continue until the Spouse's death.

- ❖ A Surviving Child's benefits under this Plan will terminate upon the loss of "Child" status, as that term is defined in the Plan.

Recoupment of overpaid benefits. The Trust has the right to recoup overpaid benefits; and the Beneficiary is obligated to repay the Trust for overpaid benefits.

- **Can my benefits be reduced by Plan amendment or termination?**

Yes. The Trustees reserve the right to modify benefit coverage and benefit levels, or to terminate the Plan, and such changes may apply to current and/or future Beneficiaries. In the event the Plan is terminated, any Plan assets that remain after payment of expenses associated with termination will be allocated and distributed to the Beneficiaries in accordance with Section 501(c)(9) of the Internal Revenue Code. See Plan Section 3.4 for details.

Possible Forfeiture from Individual Account.

- ❖ Any balance left in the Individual Account upon the death of the Beneficiary and his/her surviving Beneficiaries will forfeit to the Trust.
- ❖ If the balance in an Individual Account reduces to, and remains at, three hundred dollars ($300) or less for a period of twelve (12) consecutive months, the Trust Office will notify the Beneficiary that the Individual Account will be subject to forfeiture, according to guidelines determined by the Trustees.

- **When do I need to contact the Trust Office to update my personal information?**

You should contact the Trust Office with any changes you experience that might affect your benefits or rights from the Trust, including, but not limited to, the following:

- ❖ Change in your mailing address, e-mail address or personal cell phone number;
- ❖ Change in your employment status (e.g., retirement, lay-off, or reduction in hours);
- ❖ Change in your spouse (e.g., divorce, marriage, or death), and/or
- ❖ New children (e.g., by birth or adoption).

The Trust Office relies on such information to administer the Trust, for example, to send to Beneficiaries benefit payments and other notices related to the Plan. **Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under the Plan.**

PART 6
SURVIVOR BENEFITS

- **What benefits will my spouse and children receive if I die?**

Regular Beneficiaries receiving monthly benefits. A Surviving Spouse of a Regular Beneficiary with Children (as defined in the Plan) is eligible for monthly benefits equal to 100% of the benefit level of the deceased. The monthly benefit level for a Surviving Spouse of a Regular Beneficiary without Children is equal to 50% of the benefit level of the deceased. If there is no Surviving Spouse, the monthly benefit level for Surviving Children of a Regular Beneficiary will be 50% of the benefit level for the deceased Eligible Retiree (to be divided among Children).

Individual Account Benefits. If the deceased Retiree had an Individual Account with a positive balance, then his/her Surviving Spouse will be entitled to reimbursement benefits in an amount equal to the balance of the decedent's Individual Account. If there is no Surviving Spouse, then the Child(ren) of the deceased will be entitled to the Individual Account benefits.

- **Are there benefits for my Domestic Partner in the event of my death?**

No; the Plan provides benefits for legal spouses, who are either opposite or same sex. Due to the cost of compliance with federal tax regulations and the required taxation of domestic partner benefits, the Plan does not provide benefits for domestic partners or surviving domestic partners.

PART 7
BENEFIT CLAIM & APPEAL PROCEDURES; QDROs; ASSIGNMENT

- **How do I submit my claims for benefits? What are the appeal procedures for denied claims?**

To present a claim for benefits under this Plan, you must submit a written claim on an approved claim form by three months after the end of the Plan year (the Plan Year ends June 30) in which the expense was paid. I.e., submit the claim by September 30 for claims incurred and paid in the previous Plan Year. Beneficiaries may contact the Trust Office to request an approved claim form. Note that in the event the Trust Office overpays you for benefits, the Trust will apply subsequent benefit payments against the overpaid amount until the Trust has recouped such amount.

Claims may be mailed, emailed, or faxed to the Trust Office at:

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Fax: (866) 676-1530
Phone: (877) 808-5994
Email: PORAC@vimly.com

Or you can submit your claims via the Trust website at PORACRMT.org

The claim form must be accompanied by documentation from an independent third party, which includes the following:

- ❖ The date that the medical service or supplies were provided or the dates of coverage for insurance premiums.
- ❖ A description of the medical service, supplies, or premiums.
- ❖ Proof of the Beneficiary's payment of the Covered Expense, which can include one of the following or other proof approved by the Board of Trustees:
  - o Canceled check drawn to the name of the medical service, supplies, or insurance provider.
  - o Copy of confirmation of electronic payment to the medical service, supplies, or insurance provider, including a pension statement showing a deduction for premium payments.
  - o Receipt for payment from the medical service, supplies, or insurance provider.

You may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Details regarding claim submission and appeals of denied claims are set forth in Plan Sections 3.6 and 4.1-4.3.

To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, you must submit a written request to the Trust Office within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. The Board of Trustees will hold a hearing on the appeal, and you will be entitled to present your position and any evidence in support of your appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision.

Trustee Authority. The Trustees shall have the authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of this Plan, or the benefit Plans, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision shall be binding and conclusive.

- **What is the Plan Year, and why is it important?**

  The Plan Year runs from July 1 - June 30. Claims from expenses paid during the Plan year must be submitted within three months after the end of the Plan Year, i.e., by September 30.

- **Is there a time limit for filing a lawsuit against the Trust for benefit payments, or other reasons?**

  Yes, there is a deadline for filing a lawsuit against the Trust for benefit payments, etc. You have the right to bring action in federal court pursuant to ERISA Section 502(a) no later than one year after the exhaustion of administrative remedies (i.e., the appeal process described in this SPD Part 7, and in Plan Sections 4.1 – 4.3), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint.

- **Who pays the costs of evaluating and implementing a Qualified Domestic Relations Order (“QDRO”) or Qualified Medical Child Support Order (“QMCSO”)?**

  The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse as a deduction applied to the benefit payments. The costs include, but are not limited to, the following: administrative costs for dividing the benefit level and setting up benefits for the ex-spouse; legal fees for evaluation of the court order and to advise the Trust Office on implementation of a QDRO or QMCSO; and actuarial fees to calculate the benefit level of the ex-spouse. The costs deducted from benefit payments of the Eligible Retiree and ex-spouse may vary from one divorce situation to another and may be spread amongst several months of benefit payments.

- **Can I assign or transfer my benefits and rights under the Plan to a medical provider or other entity?**

  No, the Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Covered Expenses you will submit to the Plan for payment. The Plan will not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. Details of this restriction are in Plan Section 3.7. (There is an exception for incompetent Beneficiaries with a court appointed representative. See Plan Section 3.6(g).)

PART 8
ADMINISTRATION & THE BOARD OF TRUSTEES

- **Who is the Plan Administrator?**

The fiduciary of the Plan (known under federal law as the "Plan Administrator") is the Board of Trustees of the PORAC Retiree Medical Trust. The Board has retained the services of a contract administrator (the "Trust Office") to assist in recordkeeping, claims payments, etc. You may contact the Board in care of the Trust Office.

- **What are the names and addresses of the Trustees?**

Brian Dutton (Region I)
Gilroy Police Department
7301 Hanna Street
Gilroy, CA 95020
Cell: (408) 799-9175
Brian.Dutton@hotmail.com

Terry A. Moore (Region II)
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Chico, CA 95926
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Steve Saucedo
Burbank Glendale Pasadena Airport Police Officers' Association
2627 Hollywood Way
Burbank, CA 91505
Cell: (818) 913-1426
stevesaucedo@ymail.com

Dennis Hashin (Region IV)
17151 Pleasant Circle
Huntington Beach, CA 92649
Cell: (714)-469-0215
dhashin@msn.com

Timothy Davis, President
Sacramento Police Officers Association
550 Bercut Drive
Sacramento, CA 95811
Cell: (916) 690-5349
tdavis@spoa.org

- **How do I contact the Trust Office?**

You can contact the Trust Office at:

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
or 12121 Harbour Reach Dr, Mukilteo, WA 98275
Fax: (866) 676-1530
Phone: (877) 808-5994
E-mail: PORAC@vimly.com

PART 9
GENERAL INFORMATION ABOUT THE PLAN & TRUST

- **What are the official name and identification numbers of the Plan and Trust?**

This Plan is known as the "Medical Expense Reimbursement Plan of the PORAC Retiree Medical Trust," restated and effective January 1, 2022, and as amended thereafter (*Incl. Am. Nos. 1-21*) The Plan is governed by the "Restated Trust Agreement Governing the PORAC Retiree Medical Trust," effective January 1, 2022, and as amended from time to time thereafter ("Trust Agreement"). For a copy of the Plan or Trust Agreement, please contact the Trust Office. You may also view these documents on the website of the PORAC Retiree Medical Trust, which is: PORACRMT.org

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 80-6049077.

The Plan number is 501.

- **What is the name, address and telephone number of the employee organization that established this Plan?**

The Plan was established by the Peace Officers Research Association of California ("PORAC"), which is a professional federation of local, state, and federal law enforcement associations located within the state of California. The name, address and telephone number of the Association is as follows:

Peace Officers Research Association of California
2940 Advantage Way
Sacramento, CA 95834

Phone: (916) 928-3777
(800) 937-6722

- **What type of plan is the Medical Expense Reimbursement Plan?**

The Plan is a welfare benefit plan providing health insurance premium and medical expense reimbursement benefits to retirees.

PART 10
FUNDED BY CONTRIBUTIONS NEGOTIATED BY PARTICIPATING ASSOCIATIONS

- **Are there bargaining agreements that address contributions to this Plan and Trust?**

Yes, participation must be pursuant to a provision that your Association negotiates into your MOU. The Plan is maintained pursuant to various collectively bargained Memoranda of Understanding ("MOUs"), and applicable successor agreements, between the participating PORAC Associations and respective employers. Beneficiaries may obtain copies of the MOUs upon written request to the Trust Office. The Trustees may impose a reasonable charge to cover the cost of copies.

- **What is the source of contributions to the Trust, and how are the assets protected?**

❖ Source of Contributions. Generally, there are two sources of Contributions – monthly employer and/or employee contributions from payroll, and transfers of accrued leave. There is no individual choice to contribute, i.e., contributions must be mandatory for everyone in the bargaining unit.

❖ Monthly Employee/Employer Contributions: Monthly employer and/or employee contributions must be non-elective, that is, Contributions must be mandatory for everyone in the bargaining unit and made pursuant to an MOU. Further, the Contribution rate must be the same for everyone in the bargaining unit and made at some multiple of $25/mo, but no less $100/mo. Contributions can be made up of employer contributions, employee contributions, or a combination of employer and employee contributions. (For the first year only, the contribution rate can be $50/mo.)

Under certain limited circumstances, Beneficiaries may make elective COBRA self-payment contributions.

- ❖ Accrued Leave Transfers: Transfers of accrued vacation and/or sick leave must be non-elective, that is, transfers must be mandatory for everyone in the the bargaining unit and made pursuant to an MOU or Special Agreement. Further, transfers must be made at the same percentage (e.g., 25% or 50%) for everyone in the bargaining unit.

- ❖ Protection of Assets. Contributions are received and held in trust, and are invested by the Trust with the assistance of a professional investment manager, using investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 (ERISA).

PART 11
LEGAL RIGHTS

- **What is the name and address of the agent for service of process?**

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Trustee or the Trust Office at PORAC Retiree Medical Trust Office c/o Vimly Benefit Solutions, Inc., 12121 Harbour Reach Drive, Suite 105, Mukilteo, WA 98275.

- **What are my legal rights under applicable federal statutes?**

A. Family Medical Leave Act

Please contact the Trust Office and/or your Employer if you would like to take advantage of your right to self-pay contributions under the Family and Medical Leave Act (“FMLA”). If a covered Employee ceases active employment due to an Employer-approved family or medical leave of absence in accordance with the requirements of the Family and Medical Leave Act (Public Law 103-3), or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during the leave, the Employee will continue to earn Active Service and Active Service Units under the same terms and conditions which would have applied had the Employee continued in active employment, provided the Employee self-pays Contributions. Contributions will remain at the same level as was in effect on the date immediately prior to the leave (unless Contribution levels change for other Employees in the same classification). An Employee may be eligible to self-pay under FMLA during a leave for one of the following reasons:

- ❖ For the birth and care of a newborn child of the Employee;

- ❖ Placement with the Employee of a child for adoption or foster care;
- ❖ To care for an immediate family member (spouse, child, or parent) with a serious health condition; and
- ❖ To take medical leave when the Employee is unable to work because of a serious health condition.

An FMLA leave will be deemed to terminate on the earlier of the following dates:

- ❖ The date the Employee uses up his FMLA leave entitlement.
- ❖ The date the Employee informs the Employer of his intent not to return from leave.

B. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Please contact the Trust Office if you are a veteran leaving to, or returning from active duty and would like to take advantage of your right to self-pay contributions under USERRA. You will be able to self-pay contributions retroactively for the time of your active service duty, subject to certain restrictions.

C. Consolidated Omnibus Budget Reconciliation Act (COBRA)

For a description of your rights under COBRA, please see the General COBRA Notice, provided at the end of this Summary Plan Description. Also, if you would like to request a copy of the General COBRA Notice, please contact the Trust Office.

D. Divorce: Qualified Domestic Relations Order (QDRO)

Alternate Payees can obtain a monthly benefit pursuant to a QDRO, which generally awards the Alternate Payee a portion of the Employee's benefit. More information about what Alternate Payees can receive under this Plan and when their benefits may commence are set out in the Plan Document. Beneficiaries can obtain from the Trust Office, without charge, a model QDRO for this Plan, and a copy of the procedures governing the determination of whether a Domestic Relations Order is qualified. The Trust may assess a fee on the Employee/Eligible Retiree and/or Beneficiary for the review process. (The same applies for Medical Child Support Orders.)

E. Qualified Medical Child Support Order (QMCSO)

Beneficiaries can obtain, without charge, a copy of such procedures governing the determination of QMCSO by contacting the Trust Office.

F. Important Information: Statement of Legal Rights

❖ Rights of Plan Participants. Beneficiaries of the PORAC Retiree Medical Trust are entitled to certain rights and protections under the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- ♦ Examine, without charge, all documents governing this Plan, including MOUs, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, at the Plan Administrator's office and at other specified locations, such as worksites and union halls. The annual report is also available at the Public Disclosure Room of the Employee Benefits Security Administration.

- ♦ Obtain copies of documents governing the operation of this Plan, including collective bargaining agreements, the latest annual report, and an up-to-date Summary Plan Description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- ♦ Receive a summary of the Plan's annual financial report (SAR). The Plan Administrator is required by law to furnish each enrollee with a copy of the SAR. You can also review this on the Trust's website: PORACRMT.org

- ♦ Continue contributions to the Plan by self-payment under COBRA, if there is a cessation of contributions to the Plan as a result of a COBRA qualifying event. See the General COBRA Notice and Plan Sections 2.2(d) and 2.2(e) for rules governing COBRA continuation coverage rights.

❖ Prudent Actions by Plan Fiduciaries. ERISA imposes certain obligations upon the persons who are responsible for the operation of this employee welfare benefit plan. The persons who operate your Plan and Trust are legal "fiduciaries." Fiduciaries must act solely in the interest of the Plan Beneficiaries, and must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to compensate the Trust for any losses they cause to the Trust. No one, including an employer, may fire or otherwise discriminate against members to prevent them from obtaining a welfare benefit or from exercising their rights under ERISA.

❖ Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you and your Beneficiaries 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, you can take steps 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 thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

❖ Assistance with Your Questions. If you have any questions about this 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 (EBSA), U.S. Department of Labor, 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 at (866) 444-EBSA (3272).

❖ Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health benefit plans to protect the privacy of "protected health information." In the course of providing benefits to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to limit access to protected health information to only those persons who need to know it in order to process, complete, or administer the Plan benefits. If you would like more details about your privacy rights or a copy of the Privacy Notice, please contact the Trust Office.

APPENDIX A

Unit Multiplier

Operative Period	Unit Multiplier
May 18, 2010 – September 30, 2015	**$0.67**
October 1, 2015 – September 30, 2018	**$0.70**
October 1, 2018 – September 30, 2021	**$0.74**
October 1, 2021 -- Present	**$0.77**

- The Unit Multiplier (UM is a factor in the calculation of the monthly benefit level for an Eligible Retiree who is a Regular Beneficiary (see Section 3.3 of the Plan).
- "Operative Period" means the period during which the corresponding Unit Multiplier is used to calculate the monthly benefit level for Retirees receiving benefits during that period.
- The Trustees have the authority to modify the UM for Eligible Retirees from time to time. Any such modifications may apply to some or all current and/or future Beneficiaries, as determined by the Board of Trustees.

APPENDIX B
EXAMPLES OF CALCULATION OF BENEFIT LEVEL
PORAC RETIREE MEDICAL TRUST

$50 monthly contribution – 1 Active Service Unit Unit Multiplier,[6] effective October 1, 2021 = $0.77

Example #1 – 6 years in Trust: An Association has a contribution rate of $100/month, and Employee No. 1 participates for two (2) years (or 24 months) at that level. Then the Association increases the contributions rate to $150/month, and Employee No. 1 participates for four (4) years (or 48 months) at that level, and then retires. The monthly amount available to Employee No. 1 for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly contributions to Active Serve Units.
$100/month = 2 Active Service Units/Month
$150/month = 3 Active Service Units/Month

Step 2: Find number Active Service Units.
2 Active Service Units x 24 months = 48 Active Service Units
3 Active Service Units x 48 months = 144 Active Service Units
Total = 192 Active Service Units

Step 3: Multiply number of Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 192 x $0.77 = $147.884

* * * * *

Example #2 – 13 years in Trust: An Association selects a contribution rate of $100/month, and Employee No. 2 participates for seven (7) years (or 84 months) at that level. Then the Association increases the contributions rate to $200/month, and Employee No. 2 participates for five (5) years (or 60 months) at that level, and then retires. Then the monthly amount available to Employee No. 2 for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly contributions to Active Serve Units.
$100/month = 2 Active Service Units/Month
$200/month = 4 Active Service Units/Month

Step 2: Find number Active Service Units.
2 Active Service Units x 84 months = 168 Active Service Units
4 Active Service Units x 60 months = 240 Active Service Units
Total = 408 Active Service Units

Step 3: Multiply number of Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 408 x $0.77 = $314.16

[6] The Trustees have the authority to modify the Unit Multiplier (UM) from time to time for both existing and future Beneficiaries; they work with a professional actuarial firm to determine the UM.

* * * * *

<u>Example #3 – 25 years in Trust</u>: An Association selects a contribution rate of $100/month, and Employee No. 3 participates for seven (7) years (or 84 months) at that level. Then the Association increases the contributions rate to $200/month, and Employee No. 3 participates for eighteen (18) years (or 216 months) at that level, and then retires. Then the monthly amount available to Employee No. 3 for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly contributions to Active Serve Units.
$100/month = 2 Active Service Units/Month
$200/month = 4 Active Service Units/Month

Step 2: Find number Active Service Units.
2 Active Service Units x 84 months = 168 Active Service Units
4 Active Service Units x 216 months = 864 Active Service Units
Total = 1032 Active Service Units

Step 3: Multiply number of Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 1032 x $0.77 = $794.64

* * * * *

<u>Caveat</u>: These are examples. The Trustees reserve the right to modify the Unit Multiplier and the formula used to calculate benefit levels at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Trust. For more details, please contact the Trust Office: Vimly Benefit Solutions, Inc. (425) 771-7359.

APPENDIX C
LEAVE CONVERSION TABLES

Section 2.2(c) of the Plan sets forth the terms and conditions under which the Plan will convert accumulated sick and/or vacation leave into Active Service Units ("ASUs"). The Leave Conversion Tables below illustrate how many ASUs an Employee will earn when his/her employer transfers the value of accumulated leave to the Trust, if the Employee elects to convert the leave to ASUs.

- The number of ASUs an Employee earns as a result of the transfer of leave is calculated by the following formula:

  [Dollar amount transferred] divided by [applicable cost for one ASU]

- The cost for one ASU depends on the age of the Employee at the time of the Leave Transfer, as determined by the professional actuarial firm engaged by the Trustees.

- **These leave conversion tables assume a leave transfer of $1,000**. Note for comparison purposes that, each $50 monthly Contribution made during active employment gives an Employee one ASU.

Age at Leave Transfer	**Cost for One Active Service Unit ("x")**	**Number of ASUs Earned with $1000 ($1,000 / x) (Rounded down to nearest whole number)**
Age 25	18.78	53
Age 26	20.00	50
Age 27	21.30	46
Age 28	22.68	44
Age 29	24.15	41
Age 30	25.72	38
Age 31	27.40	36
Age 32	29.18	34
Age 33	31.07	32
Age 34	33.09	30
Age 35	35.24	28
Age 36	37.54	26
Age 37	39.98	25
Age 38	42.57	23
Age 39	45.34	22

Age at Leave Transfer	**Cost for One Active Service Unit ("x")**	**Number of ASUs Earned with $1000 ($1,000 / x) (Rounded down to nearest whole number)**
Age 40	48.29	20
Age 41	51.43	19
Age 42	54.77	18
Age 43	58.33	17
Age 44	62.12	16
Age 45	66.16	15
Age 46	70.46	14
Age 47	75.04	13
Age 48	79.92	12
Age 49	85.11	11
Age 50	90.64	11
Age 51	96.54	10
Age 52	102.81	9
Age 53	109.49	9
Age 54	116.61	8
Age 55	124.19	8
Age 56	123.04	8
Age 57	121.82	8
Age 58	120.55	8
Age 59	119.23	8
Age 60	117.85	8
Age 61	116.42	8
Age 62	114.93	8
Age 63	113.37	8
Age 64	111.73	8
Age 65	110.02	9
Age 66	108.21	9
Age 67	106.32	9
Age 68	104.32	9
Age 69	102.24	9
Age 70	100.07	9

COBRA GENERAL NOTICE
OF THE
PORAC RETIREE MEDICAL TRUST

<< IMPORTANT COBRA INFORMATION >>
THIS COBRA INFORMATION WILL INFORM YOU OF YOUR RIGHTS AND OBLIGATIONS UNDER COBRA. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

Under this type of health plan, i.e., a retiree medical expense reimbursement plan, COBRA benefits mean the right to continue contributions to the Trust, in order to obtain certain Plan benefits after retirement. This Plan gives the Employee (or family member) the right to self-pay contributions into the Trust, which were formerly paid pursuant to a collective bargaining agreement or other special agreement while the Employee was working. If you have questions regarding the eligibility requirements under the Plan, or are in doubt about the application of COBRA under this Plan, please contact the Trust Office.

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of your health premium or medical expense costs after retirement,[7] rather than health benefits immediately following active employment. That is, this Plan is for retiree health benefits, not benefits soon after termination of active employment.

1. **COBRA Generally.** You are a participant in the "Medical Expense Reimbursement Plan" (hereafter the "Plan") of the PORAC Retiree Medical Trust (hereafter the "Trust"), which provides reimbursement towards certain medical expenses, as defined in the Plan, after retirement. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[8]

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUTIONS UNDER COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

2. COBRA Coverage Means the Right to Self-Pay Continued Contributions to Plan for Benefits After Retirement

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[7] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay coverage to terminated Employees until retirement. The Plan accepts contributions during active employment, which are held by the Trust and will be used by Employees to purchase health coverage after retirement. In the event of the Employee's death, payments to the Surviving Spouse will commence the month after the Eligible Retiree died.

[8] Public Law 99-272, Title X.

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Trust by self-payment, when contributions to the Trust would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying Event, the Plan must offer each person who is a "Qualified Beneficiary" the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a collective bargaining agreement or special agreement. By offering a Qualified Beneficiary this right, generally, the Plan is offering that individual the ability to increase his or her benefits from the Plan in one of three ways:

i) The ability to meet the eligibility requirement to become a Regular Beneficiary and receive a lifetime[9] monthly reimbursement benefit from the Plan after retirement, which he/she may not otherwise have been able to meet (see **Section 2(B)** below);

ii) To augment their monthly post-retirement benefit, if the person had already met the eligibility requirements to become a Regular Beneficiary; and/or

iii) To augment the balance in the participant's Individual Account in the Plan.

You, your spouse, and your Children could become Qualified Beneficiaries if contributions to the Trust on behalf of the covered employee cease due to a Qualifying Event.

B. Plan Eligibility Requirements. To be eligible to receive the monthly lifetime[10] medical expense reimbursement benefits (subject to Plan rules) after retirement, this Plan requires that the Employee earn 10 years of Active Service as defined in Section 2.2 of the Plan. (This requirement is reduced to five years if you were an Employee[11] at the time that your Association started participation in the Plan.) Therefore, making COBRA self-payments could make you eligible, depending on how many years of Active Service you have earned at the time of the Qualifying Event.

Further, since the Plan also provides for a gradually increasing level of benefits based on the amount of your contributions, you may be able to increase your monthly benefit level if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7** below.

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[9] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of the Plan.

[10] See footnote 6.

[11] All capitalized terms are defined in the Plan.

Finally, if you cannot become eligible for the monthly lifetime[12] benefits, your contributions are recorded separately in an Individual Account, which you can access upon separation from employment. (Note that under this circumstance, you might be making contributions at the same time you are making withdrawals from your Individual Account.)

We urge you to consult with your personal tax advisor on this matter. Note that contributions will be made with 'after-tax dollars'.

C. Consequence of Non-Election. If you do not choose to continue contributing to this Plan and have not earned 10 years (or five years, if applicable under Plan Section 2.1) of Active Service, you will be eligible to receive reimbursement benefits limited to the balance credited to your Individual Account.

D. Widowed Spouses and Children. Widowed spouses and **Children,** as defined by the Plan, may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in **Section 5** below for details.

3. Qualifying Events and Qualified Beneficiaries

A. An Employee as a Qualified Beneficiary. If you are an **Employee,** you will become a Qualified Beneficiary and have the right to self-pay contributions, if contributions to the Trust on your behalf cease due to any of the following "Qualifying Events":

(i) Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or

(ii) Reduction of Work Hours. Your hours of employment are reduced.

Either of these Qualifying Events generally gives you the right to continue self-payment of contributions to this Plan.

B. The Spouse as a Qualified Beneficiary. If you are the **spouse of an Employee** covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Trust on your spouse's behalf cease due to any of the following "Qualifying Events",[13] and provided that the Employee does not elect to self-pay contributions under COBRA*:

(i) Employee's Death. The death of your Employee spouse; or

[12] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify, limit, or terminate benefits as necessary to preserve the financial soundness of the Plan.

[13] Some health plans recognize the following Qualifying Events: 1) your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both) and 2) you become divorced or legally separated from your spouse. However, due to the structure of this plan, these are not recognized Qualifying Events.

(ii) Termination of Employee's Employment. A termination of employment (for reasons other than gross misconduct) of your Employee Spouse; or

(iii) Reduction of Employee's Work Hours. A reduction in the hours of employment of your Employee Spouse.

*Note: Only one member of a family may make self-payment contributions in this type of health plan. If there are multiple Qualified Beneficiaries, for example a former employee and a spouse, you should confer together and decide whether electing to make COBRA self-pay contributions makes sense in your case, and which of you will make the election. It is important to note that due to the nature of this type of Plan, you do not each have independent rights to elect self-payment. This means that only one Qualified Beneficiary can self-pay.

C. A Child as a Qualified Beneficiary. If you are a **Child of an Employee** covered by this Plan, and neither of your parents elects to self-pay contributions under COBRA, you may become a Qualified Beneficiary and have rights to self-pay contribution to this Plan if contributions to the Trust on your parent's behalf cease due to any of the following Qualifying Events, and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

(i) Death of Parent. The death of the parent who is the Employee; or

(ii) Termination of Employee's Employment. The termination of employment (for Reasons other than gross misconduct) of the Employee parent, or

(iii) Reduction of Parent's Work Hours. A reduction in hours of employment of the Employee parent, where neither the employee parent nor spouse elect to self-pay contributions under COBRA.[14]

*See "Note" under **Section 3(B)** above.

4. Notification of Qualifying Event

A. Employer's Notification Responsibility. The Plan will offer the COBRA option to self-pay contributions to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** has the obligation to notify the Plan Administrator of the Qualifying Event. However, we urge the employee to also give notice to the Plan, in case the employer fails to do so.

B. Qualified Beneficiary's Notification Responsibility. Under COBRA, the **Employee or a family member has the responsibility** to provide written notice, within the time limits

[14] Under some plans, a child losing Child status under the plan would be a Qualifying Event, but because of the plan design of this Plan, this event is not a Qualifying Event under this Plan.

described in **Section 4(C)** below, to the Trust Office of the occurrence of any of the following Qualifying Events:

(i) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to self-pay contributions under COBRA for a maximum period of eighteen (18) months (or twenty-nine (29) months in the case of a disability, as described in **Section 6** below); or

(ii) A determination by the Social Security Administration that a Qualified Beneficiary has become disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or

(iii) A determination by the Social Security Administration that a Qualified Beneficiary who was determined as disabled is no longer disabled.

C. Timing Requirements for Qualified Beneficiaries to Notify the Trust Office of Qualifying Events

(i) Qualifying Events Other Than Disability. If a second Qualifying Event occurs, the Employee or other Qualified Beneficiary must **notify the Trust Office no later than sixty (60) days after** the latest of:

(a) *Qualifying Event.* The date that the Qualifying Event occurs; or

(b) *Contributions to the Trust Cease.* The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

(c) *The Date you Receive Notice.* The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

(ii) Qualifying Event of Disability. If the Qualifying Event is a determination that a Beneficiary is disabled, the Employee or other Qualified Beneficiary must **notify the Trust Office no later than sixty (60) days after** the latest of the following events (but no later than the end of the first eighteen (18) months period of self-payment contributions):

(a) *Determination by Social Security Administration.* The date of the disability determination by the Social Security Administration;

(b) *Disability.* The date that the disability occurs;

(c) *Contributions to the Trust Cease.* The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

(d) *The Date you Receive Notice.* The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

(iii) Change of Disability Status. The period of time for providing notice to the Trust Office of a change in disability is **thirty (30) days after** the latest of:

(a) *Determination by Social Security Administration.* The date the Social Security Administration determines that you are no longer disabled; or

(b) *Notice of Responsibility and Procedure.* The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice to the Trust Office (see **Section 5** below).

5. Procedures for Notifying Plan of Qualifying Event. Subject to the time limits in **Section 4(C)** above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s), described in **Section 4(B)** above, to the Trust Office by either first class mail or facsimile (fax). The contact information for the Trust Office is as follows:

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Fax: (866) 676-1530
Phone: (877) 808-5994
E-mail: PORAC@vimly.com

The notice of the Qualifying Event should include:

A. Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

B. Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

C. Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

When the Trust is notified that one of these Qualifying Events has occurred, it will, in turn, notify you about details concerning your election to continue your contributions to the Trust for the right to receive future benefits.

6. Maximum Length of COBRA Payments. Once you have elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within forty-five (45) days of your election. Subsequent periodic payments must be made on a monthly basis and are due on

the first of each month, but no later than thirty (30) days following the first of the month. **You will not receive monthly reminders that payment is due.**

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment of contributions to the Trust.

(i) 18 Month Period. When the Qualifying Event is a termination of employment or reduction in hours of employment, the law requires that you be given the opportunity to self-pay contributions for eighteen (18) months.

(ii) 36 Month Period. When the Qualifying Event is death of the covered employee the COBRA law requires that you be given the opportunity to continue to make contributions to the Trust by self-payment for thirty-six (36) months (three years).

B. Second Qualifying Event Extension (18 month extension of the initial 18 month period). If a second Qualifying Event, other than termination of employment, occurs during the eighteen (18) month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to eighteen (18) months of self-payment contributions, for a maximum of thirty-six (36) months. See **Sections 4 and 5** relating to notification requirements and procedure in the case of a second Qualifying Event.

C. Disability Extension (11 month extension of the initial 18 month period). If a Qualified Beneficiary under the Plan is determined by the Social Security Administration to be disabled, the Plan beneficiaries may be eligible to self-pay for an additional eleven (11) months, for a total of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of the COBRA self-payment contributions and must last at least until the end of the 18-month period of self-payment contributions. See **Sections 4 and 5** relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional eleven (11) months maybe approximately 50% higher than the amount the first eighteen (18) months if the self-payment contributions include a disabled beneficiary and the extension of period for self-payment contributions would not be available in the absence of a disability.

7. Termination of COBRA Payments. The COBRA law provides that your right to continue COBRA payments may be terminated prior to the full self-payment period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

A. The Trust no longer maintains the Plan;

B. Your employer no longer contributes to the Plan on behalf of employees;

C. The monthly self-pay contribution to the Trust under COBRA is not paid timely;

D. You qualified to make an extra eleven (11) months of self-pay contributions based on disability, but there has been a final determination that you are no longer disabled.

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

8. Refund of Contributions Erroneously Paid. Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Plan Administrator and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to self-pay contributions. Any Active Service granted based on an erroneous contribution will be rescinded.

9. Questions about COBRA. If you have any questions about the Plan or your COBRA continuation self-payment rights, you should contact the Trust Office at the address and/or phone number appearing below.

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Fax: (866) 676-1530
Phone: (877) 808-5994
E-mail: PORAC@vimly.com

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

10. Address Changes. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in marital status or address of yourself and family members. Send all address changes to the Trust Office address stated in **Section 9** above. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICE OF PRIVACY PRACTICES
WITH RESPECT TO PROTECTED HEALTH INFORMATION
OF THE
PORAC RETIREE MEDICAL TRUST

Introduction: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to "protected health information" ("PHI"), which is information that identifies a particular individual and relates to (1) the past, present, or future physical or medical condition of the individual; (2) provision of health care to the individual; or (3) payment for the provision of health care to the individual. The PORAC Retiree Medical Trust (the "Trust") is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the manner in which it may be used or disclosed.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **Our Duties Concerning Protected Health Information**: As the administrative agent for the Board of Trustees of the Trust, we are required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your protected health information. We are also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations, and you can obtain further information by contacting the Privacy Contact Officer identified in Section VII of this Notice.

If any applicable state or federal law imposes limitations upon uses and disclosures of protected health information that are more stringent than the limitations imposed under the Privacy Rule, we are required to adhere to those more stringent limitations.

II. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**: Except with respect to uses or disclosures of PHI that require an authorization as described in Section IV of this Notice, we may use or disclose PHI for treatment, payment, or health care operations as set forth in Paragraphs II.A – II.D, below, without obtaining your consent. We may elect to obtain your consent to use or disclose PHI for such purposes, although we are not required to do so. Moreover, such consent shall not be effective to permit a use or disclosure of PHI that requires an authorization as described in Section IV of this Notice.

A. <u>Uses and Disclosures for Payment of Premium Reimbursement Claims</u>. "Payment" includes but is not limited to, actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to premium reimbursement.

B. <u>Uses and Disclosures for the Payment Activities of Another "Covered Entity</u>." PHI may be shared with other "covered entities," which include health care providers and health plans, in certain circumstances. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. Disclosures to Another Covered Entity for Health Care Fraud and Abuse Detection or Compliance or Health Care Operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains and information disclosed pertains to that relationship.

D. Disclosures to the Board of Trustees of the Trust, as the Plan Fiduciary, as Necessary for Trust Administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

III. **Other Uses and Disclosures Permitted or Required Without Authorization**: We may, by complying with the requirements specified in the Privacy Rule, use or disclose PHI without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

A. When and to the extent such use or disclosure is required by law.

B. For public health activities or public health oversight authorized by law.

C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.

E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, reporting crime in emergencies, or if the information constitutes evidence of criminal conduct on our premises.

F. For coroners, medical examiners, and funeral directors to perform their legal duties.

G. For procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

H. For research purposes where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.

J. For specialized government functions related to military personnel, veteran’s benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.

K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.

L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information, if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

IV. **Authorization Required for Other Uses and Disclosures**: Uses and disclosures of PHI other than those identified above will be made only with your written authorization. You may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or the policy itself.

V. **Individual Rights**: All participants have the following rights with respect to PHI that the Plan maintains about them:

A. **Restrictions on Uses and Disclosures**. You may request that we restrict uses or disclosures of PHI for the purposes of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care. We are only required to agree to your request if you seek to prevent disclosure to a health plan for the purpose of carrying out payment or health care operations (not for the purpose of treatment), and the PHI pertains only to a health care item or service for which you have paid the health care provider out-of-pocket in full.

Except as described above, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement to restrict certain uses and disclosures with respect to PHI created or received after notifying you of the termination. Until then, we will be required to abide by the restriction unless the information is required for purposes such as: giving you emergency treatment; assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name in a health care facility directory if you are incapacitated or in emergency circumstances; or responding to those circumstances described in Section III of this Notice in which an opportunity to agree or object need not be provided.

B. **Confidential Communications**. We must accommodate reasonable requests to have PHI communicated to you in confidence by alternative means or at alternative locations. We may require your request to be in writing, to state (if appropriate) how payment for the accommodation will be handled, to specify an alternative method of contacting you, and to state that disclosure of all or part of the PHI could endanger you.

C. **Access for Inspection and Copying**: You may request access to inspect or copy PHI that is maintained about you in a designated record set. If we grant your request we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and costs to which you have agreed in advance for preparing an explanation or summary. If we deny your request, in whole or

in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other PHI subject to your request.

We may in some circumstances deny your request without providing an opportunity for review, as when the information consists of psychotherapy notes or was compiled for use in a legal or administrative proceeding, and certain other circumstances. There are other circumstances in which we must provide an opportunity for review of our denial, as when the denial is based upon a determination that provision of the information is likely to cause substantial harm to you or another person. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contract Officer identified in Section VII of this Notice if you believe our denial was improper.

D. **Amendments**: You may request amendments to PHI maintained about you in a designated record set. If we accept your request in whole or in part, we must identify the information affected thereby, provide a link to the amendment, and make reasonable efforts to notify within a reasonable time persons disclosed by you or known to us who might foreseeably rely on the information to your detriment. We may deny your request if we determine that the information subject to your request is already accurate and complete, is not part of the designated record set, would not be available for inspection as described in Paragraph V.C, above, was not created by us, and in certain other circumstances.

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link to the request, our denial, and any statements of disagreement and rebuttal. We will also be required if asked by you to include your request for amendment and our denial with any future disclosures of the information subject to your request. If you submit a statement of disagreement, we will be required to include your request for amendment, our denial, your statement of disagreement, and any rebuttal statement with any subsequent disclosure of the information to which the disagreement relates. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contract Officer identified in Section VII of this Notice if you believe our denial was improper.

E. **Accountings of Disclosures**. You may obtain an accounting of our disclosures of PHI about you during any period up to six years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same 12-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

F. **Paper Copies of this Notice**. Regardless of the form in which you have chosen to receive this Notice from us, you may receive a paper copy at any time from the Privacy Contact Officer identified in Section VII.

VI. Changes to Privacy Practices. We must change our privacy practices when required by changes in the law. We reserve the right to make other changes to our privacy practices or to this Notice that comply with the law. Whenever a change to our privacy practices materially affects the contents of this Notice, we will prepare a revised Notice and send it within 60 days to individuals then covered by the Plan. The Privacy Contact Officer identified in Section VII will also provide a current copy of this Notice upon request. A change to our privacy practices that requires a revision of this Notice may not be implemented before the effective date of the revised Notice. However, we reserve the right make the terms of any revised Notice effective for all PHI that we maintain.

VII. Additional Information and Complaints. You may as specified below obtain additional information and/or submit complaints regarding our duties and your rights with respect to protected health information:

A. Privacy Contact Officer. The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy Contact Officer, whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice:

PORAC Retiree Medical Trust
c/o Vimly Benefit Solutions
Attn: Privacy Contact Person
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (206) 859-2600

B. **Privacy Complaints.** You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Officer or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

C. **No Intimidation or Retaliation.** No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a Privacy Complaint.

VIII. **Effective Date**: This notice shall become effective on the 17th day of February, 2010, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI.

PHI use and disclosure is regulated by federal law, 45 CFR parts 160 and 164 subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.

From: BOARD OF TRUSTEES
PORAC RETIREE MEDICAL TRUST
Trust Office phone number: (877) 808-5994