SUMMARY PLAN DESCRIPTION

for the

MEDICAL EXPENSE REIMBURSEMENT PLAN

of the

PORAC RETIREE MEDICAL TRUST

Based on Plan effective July 1, 2025
(as amended thereafter).

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

Dr. 3/30/26

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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 Memorandum of Understanding. By contributing to the Trust, you are pre-funding for the payment of your eligible medical expenses incurred during your 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 investment 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 their retiree medical costs.

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 qualifying 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 or adoption of a child), failure to notify the Trust Office may result in loss or delay of benefit payments.
- **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, submit your claims by September 30 for expenses incurred in the previous plan year.
- **Funding.** The Trust is funded by mandatory employee/employer contributions and transfers of accrued leave or other lump sum transfers from employers, 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 Benefit Programs Administration ("BPA")
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: 877.808.5994 Fax: 562.463.5894
E-mail: poracrmt@bpabenefits.com
Website: **PORACRMT.org**

IMPORTANT NOTE: 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," restated effective July 1, 2025, 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. (Please see Part 7, below, for the Plan definitions of Surviving Spouse and Surviving Children.) 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

[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.

Retiree will have an Individual Account if one of the circumstances listed in Part 4 hereof applies to him or her.

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

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.

Cost Sharing. 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.

Reimbursement of Premiums Paid with Pre-Tax Income as Taxable Benefit Payment. Effective for insurance premiums you pay on or after July 1, 2023, the Plan allows for the reimbursement of such premiums paid with pre-tax income. Insurance premiums paid with pre-tax income on or before July 1, 2023, are not eligible for reimbursement through the Plan.

When a payment is "pre-tax," it means that the premium was paid with income that is not taxable to you. For example, suppose the money used to pay the premium was deducted from you or your spouse's salary or wages before taxes were calculated. In that case, that amount will not be considered taxable income on you or your spouse's personal income tax return. The IRS has taken the position that you have already received a tax break when pre-tax monies were used to pay the premiums. Therefore, reimbursements of premiums paid with pre-tax income could lead to an impermissible double-tax (free) benefit under IRS regulations.

Although the Plan allows for reimbursement of premiums paid with pre-tax income, the IRS requires the Plan to issue a Form 1099 to a Plan participant showing that he or she has received taxable income from the Plan. This includes premiums deducted from taxable income by public safety retirees pursuant to the Healthcare Enhancement for Local Public Safety Officers (HELPS) Act. The HELPS Act permits public safety retirees to deduct $3,000 of their pension income used to pay their healthcare insurance premiums as non-taxable income on their personal income tax return.

A Form 1099 will be issued to Plan participants who submit claims for reimbursement of insurance premiums where the Claim Form documentation indicates that the premiums were paid on a "pre-tax" or "tax-deferred" basis. The Claim Form allows you to indicate that you want a taxable benefit payment for reimbursement of premiums paid with pre-tax income or premium payments deducted on your personal income tax return. Claim Forms can be obtained by contacting the Trust Office or by going to the Trust website at PORACRMT.org.

Note re Christian sharing ministries. Please note that the IRS currently does not allow a tax deduction for contributions to cost-sharing ministries, such as the Christian Healthcare Ministries. Accordingly, such contributions generally do not qualify as a Covered Expense under this Plan. Please check with the Trust Office for the latest status of 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, up to 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

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

  (Return to any employment with a Participating Employer after retirement will cause a suspension of benefit payments for the length of that re-employment. Benefit payments will resume upon separation from all employment with Participating Employers.)

- **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.

[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.

- ❖ 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 monthly 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, which are available in this circumstance.)

  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 sufficient 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.

[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

- **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 total 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 and other lump sum transfers into Active Service Units, at actuarial cost, which is based on the actual age of the Employee at the date of transfer. These lump sum transfers are credited to an Individual Account in the Employee's name. Upon establishment of the Individual Account and annually after that, the Employee or Beneficiary has the option to convert some or all of the Individual Account balance to Active Service Units. At retirement or separation from employment, an Eligible Retiree has the option to use some or all of the Individual Account balance to purchase Active Service Units through COBRA rights or through conversion. See Section 2.2(c) of the Plan. To find out the actuarial cost of Active Service Units through conversion, please refer to Appendix C at the back of this SPD, "Lump Sum Conversion Table."

  ❖ The Unit Multiplier is a factor determined by the Trustees, with actuarial advice. Currently, the Unit Multiplier is $0.80. (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 lump sum transfers 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.

- **What happens if I don't use my full monthly benefit level each month?**

If you do not use your entire monthly benefit level for one month, then the unused amount of your monthly benefit level will carry over to the next month, including during periods when use of your monthly benefit level is suspended due to rehire by a Participating Employer. For example, if your monthly benefit level is $200, but you only submit claims for reimbursement of $100, your monthly benefit level for the next month will be $300 (and if not used that month it will carry over to the following month). Carryover of unused monthly benefit level also carries over to the Surviving Spouse, and to Surviving Children, upon the death of the Eligible Retiree. However, the claims deadline for all Covered Expenses paid during the plan year (from July 1 to June 30) is September 30th, i.e., you must submit your claims timely, but if you don't use up your entire benefit level, the balance will carry over from year to year.

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 or other lump sum transfer to the Trust on his/her behalf, and the retiree did not elect to convert all of the leave transfer or lump sum 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 or other Lump Sum Transfers 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. On the date of publication of this Summary Plan Description, the account administration fee is applicable only to Account Beneficiaries who are not contributing to or eligible for monthly benefits from the pooled account. The current account administration fee is $6.75 per month, which is subject to change.

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 or suspension of benefits:

❖ An Eligible Retiree's benefits under this Plan will terminate upon his/her death. An Eligible Retiree's benefits under this Plan will be suspended upon return to employment with a Participating Employer, provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with any Participating Employer.

❖ A Surviving Spouse's benefits under this Plan will be suspended 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 of Plan Benefits.

❖ *Forfeiture of Individual Accounts at or below balance of three hundred dollars ($300)*. If the balance in an Individual Account reduces to, and remains below or

equal to, three hundred dollars ($300) for a period of twelve (12) consecutive months, then the Trust Office will notify the Beneficiary that he/she has sixty (60) days from the date printed on the notification to make a claim for benefits. If the Beneficiary does not make a claim within the 60 days, the Trust Office will close the Individual Account and forfeit the funds into the Plan's pooled account.

- *Forfeiture of Individual Account upon the death of Account Beneficiary without surviving Beneficiaries*. After the Trust Office has determined that an Account Beneficiary or Employee has no surviving Beneficiaries, his or her Individual Account will be forfeited into the Plan's pooled account, pursuant to policies and procedures established by the Trustees. The forfeited balance will be used to increase the assets of the Plan's pooled account for actuarial valuations in order to provide benefits for other Beneficiaries and pay for the Plan's operating expenses. If a surviving Beneficiary later makes a claim on the forfeited account balance, the Trust Office will reinstate the Beneficiary's Individual Account with no retroactive allocation of investment returns/interest after the date of forfeiture, subject to the terms of the Plan.

- *Forfeiture of a Regular Beneficiary's monthly benefit upon a death without surviving Beneficiaries*. After the Trust Office has determined that a deceased Regular Beneficiary has no surviving Beneficiaries, his or her monthly benefits (including any carryover of unused benefits) will be forfeited into the Plan's pooled account, pursuant to policies and procedures established by the Trustees. The forfeited benefits will be used to increase the assets of the Plan's pooled account for actuarial valuations in order to provide benefits for other Beneficiaries and pay for the Plan's operating expenses. If a surviving Beneficiary (e.g., a Surviving Spouse or Surviving Child(ren), as defined in the Plan) later makes a claim for forfeited benefits, the Trust Office will reinstate the Beneficiary's monthly benefits prospectively for the current Plan Year, subject to the terms of the Plan, including the regular claims deadline.

- *Forfeiture of monthly benefits and/or Individual Account due to status as Chronic Missing Participant.* The forfeiture policy will also apply to monthly benefits (including any carryover of unused benefits) and Individual Account balances of chronic Missing Participants. Chronic Missing Participants are Plan participants without a valid mailing address in Plan records, who could not be located after reasonable search efforts performed over 5 years. If the Chronic Missing Participant is later located, monthly benefits and/or the Individual Account balance will be reinstated prospectively for the current Plan Year, subject to the terms of the Plan, including the regular claims deadline. In the case of a reinstated Individual Account, there will be no retroactive allocation of investment returns/interest after the date of forfeiture due to inability to locate the Chronic Missing Participant.

- **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

- **Are there survivor benefits available under the Plan after my death?**

  Yes. Your Surviving Spouse, and Surviving Children (as defined in the Plan) are eligible for reimbursement of Covered Expenses after your death.

  A Surviving Spouse is the lawful spouse of an Eligible Retiree, who has been the spouse of the Eligible Retiree for at least twelve (12) months on the date of death of the Eligible Retiree. A Surviving Child is an individual who at the time of the Eligible Retiree's death met the definition of Child (as specified in the answer to the second question in Part I, above), and who continues to meet those requirements. A Surviving Child also includes a child of any age who was legally dependent upon the Eligible Retiree at the time of the Eligible Retiree's death for support and maintenance for so long as the child is determined to be disabled by the Social Security Administration.

  Benefits to Estate of Deceased Beneficiary. The duly appointed executor of the estate of a deceased Employee, Eligible Retiree or Surviving Spouse (a "Decedent") who died without a surviving Beneficiary, can make a claim against funds in either an Individual Account balance or unused monthly benefits accumulated at the time of the Decedent's death. The estate has an extended claim deadline. The claim must be submitted within 12 months after the end of the Plan year (i.e., June 30) in which the Covered Expense was paid. The Plan's other Benefit Rule Procedures will apply to such claims.

- **What benefits will my Surviving Spouse and Surviving Child(ren) 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).

  Bridge Benefit for Surviving Spouses Under Age 55: If the Surviving Spouse of a Regular Beneficiary is under age 55 at the time of death, the Surviving Spouse shall also be entitled to a temporary Bridge Benefit that runs for a period of up to 24 consecutive months (or until age 55 when a Surviving Spouse's regular survivor benefits commence, whichever is sooner). (See Plan Section 3.4(b) for more information about the Bridge Benefit.)

  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?**

  To present a claim for benefits under this Plan, the Beneficiary must submit a written claim on an approved claim form, along with supporting documentation, to the Trust Office. Beneficiaries may contact the Trust Office to request an approved claim form. Claims requesting that Plan benefits be paid from the balance of a Beneficiary's Pooled Account monthly benefit must be received by the Trust Office within 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. While the Trust office may waive the deadline for good cause shown, please do not assume that any circumstances will constitute good cause. There is no deadline applicable to claims requesting that Plan benefits be paid from the balance of a Beneficiary's Individual Account balance.

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

PORAC Retiree Medical Trust
c/o Benefit Programs Administration ("BPA")
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: 877.808.5994 Fax: 562.463.5894
E-mail: poracrmt@bpabenefits.com

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

Note: If the Trust Office overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments until the Trust has recouped the overpaid amount, or the Trust may seek repayment of the overpaid amount from you directly to the Trust.

A Beneficiary 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.

Documentation Needed for Each Claim

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 (which date must be prior to submission of the claim) or the dates of coverage for insurance premiums.
- A description of the medical services or supplies (which must qualify as tax-a deductible expense), or premiums. To prove that a medical expense is tax-deductible, the documentation must show that a medical provider ordered the medical services or supplies for treatment of a diagnosed condition or disease. This proof may require more than one document based upon your particular situation and your medical provider's processes and procedures.
- Proof of the Beneficiary's payment of the Covered Expense, which includes one of the following:
  - Canceled check drawn to the name of the medical service, supplies, or insurance provider.
  - Copy of confirmation of electronic payment to the medical service, supplies, or insurance provider.
  - Receipt for payment from the medical service, supplies, or insurance provider, including a pension (CalPERS) statement showing a deduction for premium payments.
  - Other proof approved by the Board of Trustees.

Annual Claim Form for Premium Reimbursement

For insurance premium reimbursement claims, at least annually, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates of coverage for insurance premiums
- A description of the insurance premiums, i.e., type of insurance provided

The annual claim form will advise the Trust Office of the premium amount that you will be paying for the upcoming year, and the amount that you are claiming for reimbursement from the Plan for those monthly premiums. If you have a change in premium amount before the next annual claim form collection date (e.g., due to eligibility for Medicare of adding/deleting a family member to/from your policy), then you need to submit a new claim form to the Trust Office.

Documentation Needed for Each Premium Reimbursement (Monthly)

To receive reimbursement of recurring monthly premiums (except for Medicare premiums deducted from Social Security payments), you must also submit the following information each time you want reimbursement. This is in addition to the annual documentation with the claim form described above. Generally, you must submit proof that a Beneficiary has paid the premium each month, and the payment amount must match the amount claimed on your annual claim form. See examples of proof of payment above.

You can send proof of your payment monthly, or you can batch proof of payment documentation less frequently, as long as you comply with the annual claims deadline. However, you will only be reimbursed for months for which the Trust Office has received your proof of payment. If your premium amount changes before the next annual verification request from the Trust Office (most likely due to Medicare eligibility), you must submit a new claim form and third-party insurance documentation of your new premiums.

Documentation of Medicare Premiums Deducted From Social Security Payments (Annual Statement)

Because you receive only one annual statement showing the monthly deduction for Medicare payments, you can submit that statement annually with your claim form, and the Trust Office will reimburse you monthly for that amount, up to your Benefit Level, for the rest of the year. **You do not need to submit any other documentation** unless your Medicare premium is paid via check or ACH payment. This exception applies to all

Medicare premiums, i.e., Parts A, B and D. Please note that the exception does not apply to Medicare Supplemental or Medigap premiums. If your Medicare premium changes during the year (e.g., a spouse is added to Medicare during the year or a spouse dies), then you must submit the new Social Security statement and a new claim form to the Trust Office within 30 days of receipt.

Annual Premium Payments

If you pay your insurance premium in one lump sum annually for an entire year of coverage, then you can submit a claim form, third party documentation of insurance coverage, and proof of premium payment just once per year after making your annual payment; you do not need to resubmit this same documentation each month. The Trust Office will reimburse your annual premium payment up to your Benefit Level each month until the annual premium is reimbursed in full.

Claims Payments Must Reimburse Prior Covered Expense Payments

All reimbursement payments must reimburse your prior Covered Expense payment, not a prospective payment. If you request reimbursement of insurance premiums, you may be reimbursed in the month following the month in which you paid the insurance premium depending upon the date in the month that you pay your premiums.

You may *not* submit claims for medical expenses that have been paid, or you expect to be paid, by another source, such as Medicare, a supplemental health insurance plan, or a Health Savings Account (HSA). If such double coverage is discovered, the Trust may pursue recoupment, penalties and interest against you.

- **When should I expect a decision on my claim?**

Claims are paid monthly and will be paid in the month's claim payment, provided your claim is received by the 15th of the month. If your claim is not allowed under the Plan, the Trust Office will send you a written denial of your claim, explaining the reason for the denial and referencing the Plan provisions upon which the denial is based. Within 30 days of receipt of your claim, the Trust Office will review your claim and either: approve the claim and process it for payment; send you a written denial; send you a written notification of extension of time to determine the claim; or send you a written request for additional documentation or information to support your claim. If the Trust Office requests additional documentation or information, the Trust Office will give you 45 days to respond. If you do not respond within the 45-day period, your claim will be denied.

- **What are the appeal procedures for denied claims?**

To appeal a claim denial, eligibility determination, response on clarification or enforcement of Plan rights, or to bring any other complaint, a Beneficiary 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. An appeal is considered submitted and filed with the Trust Office on the date that it is received/date stamped at the Trust Office. The Board of Trustees will hold a hearing on the appeal, and the Beneficiary will be entitled to present his or her position and any evidence in support of his or her appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

Trustee Authority. The Trustees have broad discretionary authority to determine eligibility for benefits, to grant or deny claims for benefits, to interpret and apply the provisions of this Plan, 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 is binding and conclusive.

- **What happens if I have high monthly claims in one month? Can I get the excess Covered Expenses reimbursed in a later month?**

Yes. If you submit a claim for Covered Expenses that exceed your monthly benefit level, the Trust Office will reimburse you for those excess expenses in a subsequent month when you have not submitted claims sufficient to use all of your monthly benefit level. For example, if your monthly benefit level is $200 and you submit a claim for a Covered Expense of $300, then you would receive payment for that claim at $200 in the first month, and $100 in the next month. If you submit claims of $300 in the first month, $200 in the second month, and no claims in the third month, then you will receive reimbursement for the excess $100 in the third month. The excess Covered Expense is carried over and reimbursed in a month when you have not submitted claims equal to your monthly benefit level.

- **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 must first exhaust the internal appeal procedures of the Plan before filing a claim in court. 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.

Note: The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits, and the Trustees anticipate that an action brought in federal court challenging the Trustees' exercise of their discretionary authority will be subject to a deferential standard of review.

- **What are the procedures governing Qualified Domestic Relations Order ("QDRO") and Qualified Medical Child Support Order ("QMCSO") Determinations?**

The parties to a divorce proceeding can divide the monthly benefits earned during the marital period, but that division can only be implemented pursuant to a valid QDRO, as determined by the Plan. The Plan reserves the right to determine whether a domestic relations order is a QDRO. The Trustees have adopted procedures and a model QDRO for this purpose.

Upon notice of the intent to secure a QDRO, or notice from the Trust Office to the participant regarding withholding of benefits, the Plan will segregate 50% of the community property benefits that the Employee earned during the marriage, and set those funds aside for potential future payment to the Alternate Payee (Employee's ex-spouse) after the QDRO is approved. The Plan will segregate the Alternate Payee's share of monthly benefit level and/or Individual Account for no more than 18 months from the date that this segregation begins. If the Alternate Payee obtains a QDRO prior to the end of the 18-month period, the Plan will pay the Alternate Payee his or her share of the segregated benefits in accordance with the Plan's rules for claims retroactive to the date that the Plan began segregating benefits. If the Alternate Payee fails to obtain a QDRO within this 18-month period, the Plan will pay the segregated benefits to the Employee in accordance with the Plan's rules and will stop segregating future benefits.

A former spouse of an Employee under a QDRO, known as an Alternate Payee, may commence receiving his or her portion of the monthly benefit level at a time specified in the QDRO, but no earlier than the earliest date that the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the Participating Employer on such date. An Alternate Payee's monthly benefits will not be suspended if the Employee returns to employment with a Participating Employer. An Alternate Payee's monthly benefits will terminate on the first of the month following the Alternate Payee's death.

The Surviving Children of the marriage of the Eligible Retiree and Alternate Payee may begin receiving benefits starting the month after the death of the Alternate Payee and such Surviving Children's benefits will terminate on the date the last Surviving Child no longer meets the definition of Child or the date of death of the last Surviving Child.

A QMCSO is an order issued by a state court or agency that may require a health plan subject to ERISA to provide health benefits to children.

Beneficiaries can obtain from the Trust Office, without charge, a copy of the procedures governing the determination of whether a Domestic Relations Order is qualified. Beneficiaries can also obtain, without charge, a copy of procedures governing the determination of a QMCSO by contacting the Trust Office. Beneficiaries can also obtain review of a proposed QDRO or QMCSO from the Trust Office.

The Trust will assess a fee on the Eligible Retiree and/or Alternate Payee for the costs of the QDRO and QMSCO review process (see Q&A directly below).

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

The Eligible Retiree/Employee 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/Employee and ex-spouse as a deduction applied to the monthly benefit level and/or Individual Account. The QDRO will allocate the percentage of the QDRO costs paid by each party to the divorce. 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(h).)

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, Chair (Region II)
1645 Plumas Way.
Chico, CA 95926
Cell: (530) 588-5117
CPOAPrez@sbcglobal.net

Steve Saucedo (Region III)
Burbank Glendale Pasadena Airport Police Officers' Association
13546 Haynes St.
Valley Glen, CA 91401
Cell: (818) 913-1426
stevesaucedo@ymail.com

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

Dustin Smith (Board Representative)
Sacramento Police Officers' Association
550 Bercut Drive
Sacramento CA 95811
Cell: (916) 207-0338
Email: dasmith@spoa.org

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

You can contact the Trust Office at:

PORAC Retiree Medical Trust
c/o Benefit Programs Administration ("BPA")

1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: 877.808.5994 Fax: 562.463.5894
E-mail: poracrmt@bpabenefits.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 July 1, 2025, and as amended thereafter (*Incl. Am. Nos. 1-32*). 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 503.

- **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 lump sum transfers, such as accrued leave transfers. There is no individual choice to contribute, i.e., contributions must be mandatory for everyone in the bargaining unit or defined class of 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/month, but no less $100/month. Contributions can be made up of employer contributions, employee contributions, or a combination of employer and employee contributions.

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

    The Board of Trustees has authority to determine whether to provide refund of contributions paid by a Participating Employer on your behalf and the terms that will apply to such refund, subject to applicable law.

  - ❖ Accrued Lump Sum Transfers: Transfers of accrued vacation and/or sick leave or other lump sum transfers must be non-elective, that is, transfers must be mandatory for everyone in the the bargaining unit (or defined class of 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 (or defined class of 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 Benefit Programs Administration, 1200 Wilshire Blvd., 5th Floor, Los Angeles, CA 90017.

- **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 learn more about the right to self-pay contributions during Family and Medical Leave Act ("FMLA") leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

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)

If your contributions to this Plan cease due to a leave of absence for active-duty military service, you have the right under USERRA to self-pay contributions for up to 24 months of that period of leave. 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. Regardless of whether you elect to self-pay contributions under USERRA, the Plan will preserve all Active Service that you earned prior to your period of leave and that Active Service will be added to any future Active Service that you earn after return to employment following your leave of absence.

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.

A Qualified Beneficiary must provide written notice of the following Qualifying Event(s) to the Trust Office by either first class mail, email or facsimile (fax):

- Divorce or Legal Separation;
- Loss of Child Status;
- Notice of a Second Qualifying Event
- Disability;
- Change of Disability Status

Please see Section 4 of the COBRA General Notice attached to this SPD for the notice deadlines related to specific Qualifying Events.

If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions.

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 – March 31, 2025	**$0.77**
April 1, 2025 – Present	**$0.80**

- 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 UM 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 April 1, 2025 = $0.80

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 $0.80 = $153.60

* * * * *

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 $0.80 = $326.40

[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.

* * * * *

Example #3 – 25 years in Trust: 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 = 1,032 Active Service Units

Step 3: Multiply number of Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 1,032 x $0.80 = $825.60

* * * * *

Caveat: 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: Benefit Programs Administration (877) 808-5994.

APPENDIX C
LUMP SUM CONVERSION TABLE

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 or other lump sum transfers to an Individual Account into Active Service Units ("ASUs"). The Lump Sum Conversion Tables below illustrate how many ASUs an Employee will earn when his/her employer transfers the value of the lump sum to the Trust, if the Employee elects to convert the lump sum to ASUs.

- The number of ASUs an Employee earns as a result of the lump sum transfer 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 Lump Sum Transfer, as determined by the professional actuarial firm engaged by the Trustees.
- **The lump sum conversion table assumes a lump sum transfer of $1,000**. Note for comparison purposes that, each $50 monthly Contribution made during active employment gives an Employee one ASU.

Age at Lump Sum Transfer	**Cost for One Active Service Unit ("x")**	**Number of ASUs Earned with $1000 ($1,000 / x) (Rounded down to nearest whole number)**
Age 20	14.41	69
Age 21	15.35	65
Age 22	16.35	61
Age 23	17.41	57
Age 24	18.54	53
Age 25	19.75	50
Age 26	21.03	47
Age 27	22.40	44
Age 28	23.85	41
Age 29	25.40	39
Age 30	27.05	36
Age 31	28.81	34
Age 32	30.69	32
Age 33	32.68	30
Age 34	34.80	28

Age at Lump Sum Transfer	Cost for One Active Service Unit ("x")	Number of ASUs Earned with $1000 ($1,000 / x) (Rounded down to nearest whole number)
Age 35	37.07	26
Age 36	39.48	25
Age 37	42.04	23
Age 38	44.77	22
Age 39	47.69	20
Age 40	50.78	19
Age 41	54.09	18
Age 42	57.60	17
Age 43	61.35	16
Age 44	65.33	15
Age 45	69.58	14
Age 46	74.10	13
Age 47	78.92	12
Age 48	84.05	11
Age 49	89.51	11
Age 50	95.33	10
Age 51	101.53	9
Age 52	108.13	9
Age 53	115.15	8
Age 54	122.64	8
Age 55	130.61	7
Age 56	129.36	7
Age 57	128.05	7
Age 58	126.67	7
Age 59	125.21	7
Age 60	123.68	8
Age 61	122.08	8
Age 62	120.42	8
Age 63	118.68	8
Age 64	116.85	8
Age 65	114.94	8
Age 66	112.93	8
Age 67	110.83	9
Age 68	108.64	9
Age 69	106.35	9
Age 70	103.94	9

COBRA GENERAL NOTICE
of the
PORAC RETIREE MEDICAL TRUST
MEDICAL EXPENSE REIMBURSEMENT PLAN

<< 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 care 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

[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 provide current healthcare insurance coverage. This Plan reimburses the cost of premiums or medical expenses, but not until separation or retirement and attainment of eligibility.

[8] Public Law 99-272, Title X

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.

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 receive a lifetime[9] monthly reimbursement benefit from the Plan, which he/she may not otherwise have been able to meet (see **Section 2(B)** below);

(ii) To augment their monthly benefit, if the person had already met the eligibility requirement; and/or

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

You, your spouse, and your dependent 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 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[10] 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 number of years 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

[9] The Plan is currently written to provide benefits for most Retirees 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] All capitalized terms are defined in the Plan.

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 6** below.

Finally, if you cannot become eligible for the monthly lifetime[11] benefits, your contributions are recorded separately in an Employee Account, which you can access upon separation from employment. (Note that under the circumstance that you are not able to become eligible for monthly benefits with your COBRA contributions, you might be making COBRA contributions to your Employee Account and then withdrawing those same funds for reimbursement of medical expenses.)

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 Employee Account.

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D. Widowed spouses and dependent children. Widowed spouses and dependent children 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 including a cessation of contributions on your behalf due to a leave of absence.

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

[11] See footnote 3.

due to any of the following "Qualifying Events",[12] and provided that the Employee does not elect to self-pay contributions under COBRA*:

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

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

(iii) Reduction of Spouse's Work Hours. A reduction in your spouse's hours of employment; or

(iv) Divorce. If the Employee and spouse divorce during contributions or during benefit payments, a QDRO will provide more rights to ongoing and future benefit payments than COBRA, but this is a Qualifying Event for COBRA.

*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. Child as a Qualified Beneficiary. If you are the **Child** of an Employee covered by this Plan, you may become a Qualified Beneficiary and have rights to self-pay contributions 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;

ii) Termination of Parent's Employment. The termination of the Employee parent's employment (for reasons other than gross misconduct);

iii) Reduction of Parent's Work Hours. A reduction in the Employee parent's hours of employment; or

iv) Loss of Child Status. If a Child attains age 26 and loses current reimbursement benefits under the Plan because he/she no longer qualifies as a Child under the Plan.

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

[12] Some health plans recognize the Qualifying Event of loss of coverage due to eligibility for Medicare benefits. However, there is no loss of coverage upon eligibility for Medicare under this Plan. In fact, the Plan reimburses premiums for Medicare Part A, B and D, and medical expenses not covered by Medicare.

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

1. Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan;
2. Divorce of the Employee and spouse;
3. 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);
4. A Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or
5. A Qualified Beneficiary, who was determined as disabled is subsequently determined by the Social Security Administration as no longer disabled.

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

i) Qualifying Events Other Than Disability. The period of time for providing notice to the Trust Office for a Qualifying Event is **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. The period of time for providing notice to the Trust Office of a disability determination is **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 Benefit Programs Administration ("BPA")
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: 877.808.5994 Fax: 562.463.5894
E-mail: poracrmt@bpabenefits.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 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 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.

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, divorce or loss of child status, 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; or

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

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, email and/or phone number appearing below.

PORAC Retiree Medical Trust
c/o Benefit Programs Administration ("BPA")
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Phone: 877.808.5994 Fax: 562.463.5894
E-mail: poracrmt@bpabenefits.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.

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

Introduction: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to your protected health information ("PHI"). PHI is a subset of health information that identifies or can be used to identify a particular individual and relates to the past, present, or future physical or mental health or condition of the individual, provision of health care to the individual, or payment for the provision of health care to the individual.

The *Medical Expense Reimbursement Plan of the PORAC Retiree Medical Trust* ("the Plan") is required to provide you this Notice describing our duties and your rights with respect to your PHI and the manner in which it may be used or disclosed. This Notice only applies to PHI created or received by or on behalf of the Plan.

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: The Plan is required by law to maintain the privacy of your PHI according to the terms of the Privacy Rule and other applicable laws. We are also required to abide at all times by the terms of this Notice.

If any applicable state or federal law imposes limitations upon uses and disclosures of PHI 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 set forth in Paragraphs V(A)-V(C) of this Notice, we may, without obtaining your consent, use or disclose your PHI for treatment, payment, or health care operations of the Plan or of another Covered Entity, as follows:

A. Treatment. The Plan may use or disclose your PHI to facilitate medical treatment and services by providers (such as doctors, nurses, technicians) who are involved in taking care of you. For example, we may provide your PHI to your health care provider in an emergency situation.

B. Payment. The Plan may use and disclose your PHI to determine or fulfill its responsibility for coverage and provision of benefits, including determining eligibility for Plan benefits, facilitating payment activities related to reimbursement of Covered Expenses, determining benefit responsibility under the Plan, and coordinating Plan coverage with another health plan. The Plan may also use and disclose PHI for other payment purposes as permitted by HIPAA. For example, the Plan may disclose payment on a claim to another health plan, to coordinate benefits between the two plans, or it may disclose PHI to the Board of Trustees to review and decide an appeal.

C. Health Care Operations and Administration of the Plan. The Plan may use and disclose your PHI for Plan operations. These uses and disclosures are necessary for the administration of the Plan. For example, medical information may be used or disclosed in connection with conducting quality assessment and improvement activities; to conduct data analyses for cost control, determination of benefit levels, and other activities relating to Plan coverage; conducting or arranging for legal services, audit services, and fraud and abuse detection programs; business management, including in connection with the merger or consolidation of the Plan; and for general Plan administrative activities, such as providing you with customer service. The Plan may also use and disclose your PHI for such other healthcare operations of the Plan as permitted by HIPAA.

The Plan may disclose PHI to the Plan Sponsor as necessary to perform plan administration functions.

III. **Other Uses and Disclosures Permitted or Required Without Authorization**: Except with respect to uses or disclosures set forth in Paragraphs V(A)-V(C) of this Notice, we may, by complying with the requirements and limitations 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. To the extent such use or disclosure is required by law.

B. We may disclose PHI to our Business Associates so that they can perform services for us, and they may use or disclose PHI for any or all of the same purposes for which we are permitted to use or disclose it, as well as for the Business Associate's own management and administration. Business associates are contractually required not to use or disclose your health information for any other purposes.

C. For public health activities or public health oversight, to the extent authorized by law, including reporting regarding child abuse or neglect.

D. The Plan may disclose Summary Health Information, as defined in HIPAA regulations, to the Plan Sponsor for purposes of modifying, amending, or terminating the Plan. The Plan may also disclose to the Plan Sponsor information on whether you are participating in the Plan.

E. When and to the extent required or authorized by law or authorized by you regarding a victim of abuse, neglect, or domestic violence.

F. 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; provided that certain substance use disorder records are subject to further protections as described in Section V of this Notice.

G. For law enforcement purposes, when required by law or, subject to certain conditions, pursuant to a judicial or administrative order. In addition, the Plan may disclose PHI,

to the extent and under the circumstances authorized by law, in the following circumstances: (i) for the purposes of identifying or locating an individual, (ii) about an individual who is or is suspected to be a victim of a crime, (iii) about an individual who has died, if it is suspected that the death resulted from criminal conduct, (iv) reporting crime in emergencies, or (v) if the information constitutes evidence of criminal conduct on our premises. Note that certain substance use disorder records cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against you, unless the use or disclosure is authorized based on your written consent, or by a court order after you are provided notice and an opportunity to be heard. See Section V of this Notice for more information.

H. To coroners, medical examiners, and funeral directors, to the extent authorized by law, for the performance of their duties.

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

J. For research purposes, to the extent and under the circumstances authorized by law.

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

L. 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.

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

IV. Disclosures to Personal Representatives & Family Members

A. Personal Representatives. The Plan will disclose your PHI to your personal representative under HIPAA, as verified by the Plan. You or your personal representative may be required to provide the Plan with documentation supporting your personal representative's authority to make health care decisions on your behalf. Parents are generally the personal representative of their minor children.

However, under HIPAA, the Plan does not have to disclose information to a personal representative if it has a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

B. Family, Close Personal Friends, and Others Involved in Your Health Care. The Plan may disclose your PHI to family members, close personal friends, or other people identified by you who are involved with your health care or the payment of your health

care, provided that: (1) The Plan gives you the opportunity to agree or object to the disclosure, and you do not object to the disclosure; or (2) If you are unable to agree or object due to incapacity or an emergency, the Plan determines that the disclosure is in your best interest.

V. 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. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as otherwise permitted or required by law. However, your written revocation will only be effective for future uses and disclosures, and we will be unable to take back any disclosures we have already made pursuant to your authorization.

A. Psychotherapy Notes. We are required to obtain an authorization for any use or disclosure of psychotherapy notes, except to defend the Trust in a legal action or other proceeding brought by the individual who is the subject of the notes.

B. Marketing Purposes & Sale of Your PHI: The Trust will never use your PHI for marketing purposes and will not sell your PHI, unless you provide written authorization.

C. Certain Substance Use Disorder Records. If we receive substance use disorder ("SUD") treatment records from a federally assisted substance use disorder program that is covered by 42 CFR Part 2 (a "Part 2 Program"), and we are notified of the prohibition on redisclosure in accordance 42 CFR Section 2.32, we will not use or disclose such SUD treatment records, except as described herein.

To the extent we receive substance use disorder records from a Part 2 Program, or testimony relaying the content of such records, through a single consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for all future uses and disclosures for treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in civil,

criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless the use or disclosure is authorized based on your written consent, or by a court order after you are provided notice and an opportunity to be heard, as required by 42 CFR Part 2. A court order authorizing use or disclosure of SUD records must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the requested SUD record is used or disclosed.

To authorize this Plan to use or disclose your Part 2 Program records in a manner for which you have not already consented to such use or disclosure, you must complete an Authorization form in writing and provide it to the Privacy Officer. Your authorization can be revoked in writing only by submitting your revocation request to the Privacy Officer. Any disclosure of Part 2 Program records made pursuant to an individual's written consent will be accompanied by a copy of the consent or a clear explanation of the scope of the consent.

VI. 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 or limit the Plan's uses or disclosures of your PHI to carry out treatment, payment, or health care operations or for locating and providing information to persons involved with your care or payment for your care (such as a family member or friend).

We are required to agree to your request only if the disclosure is for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) for 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 to your request, we will be entitled to terminate our agreement with respect to PHI created or received after we notify you of the termination. Until then we are 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; and circumstances described in Section III of this Notice for which an opportunity to agree or object is not required.

To request restrictions, you must make your request in writing to the Plan's Privacy Officer, using the contact information in Section VIII of this Notice. In your request, you must state: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

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, state if appropriate how payment for the accommodation will be handled, specify an alternative method of contacting you, and state that disclosure of all or part of the PHI could endanger you.

C. Access for Inspection and Copying. You may make a written request to inspect and 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 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.

D. Amendment to PHI Held in Designated Record Set. 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 VI(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 VIII 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, including information about who received your protected records, the date of the disclosure, and a brief description of the information that was disclosed. 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, under certain circumstances, we are required to suspend this right to receive an accounting of disclosures made 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 Officer identified in Section VIII.

VII. 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 post it on the Plan's website and mail it in the Plan's next annual mailing (or, if the Trust has no website, send it within 60 days to individuals then covered by the Plan). The Privacy Officer identified in Section VIII will also provide a current copy of this Notice upon request.

VIII. 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 PHI:

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

Privacy Officer
Sean Minner
c/o *Benefit Programs Administration*
1200 Wilshire Blvd. 5th Floor
Los Angeles, CA 90017
Phone: (877) 808-5994

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 Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services, Hubert Humphrey Building Room 509F, 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. The Secretary encourages you to file your complaint using the Office of Civil Rights (OCR) online portal at https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

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.

IX. **Effective Date**: This notice shall become effective on the 16th day of February 2026, and shall remain in effect until it is amended, and a revised Notice is provided to you as described in Section VII.

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

From: BOARD OF TRUSTEES
MEDICAL EXPENSE REIMBURSEMENT PLAN
OF THE PORAC RETIREE MEDICAL TRUST

Trust Office: (877) 808-5994

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