SUMMARY PLAN DESCRIPTION

MEDICAL EXPENSE REIMBURSEMENT PLAN

OF THE

CENTRAL VALLEY RETIREE MEDICAL TRUST

Including COBRA General Notice
and
HIPAA Privacy Notice

Issued: January 2021
(Incl. Plan Am. Nos. 1-12)
(Dr. 12/11/20)

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Dear Participant

The Deputy Sheriffs' Association of Stanislaus County established the Central Valley Retiree Medical Trust (the "Trust") in 2002. The Trust is an employee benefits trust designed to provide financial support during your retirement, in the form of payment toward retiree medical costs. Since that time, many other public sector employee associations have joined the Trust. Your Association has negotiated a contribution into this Trust; specific language can be found in your Memorandum of Understanding ("MOU"). By negotiating a contribution to the Trust, your Association is proactively planning for your retirement by prefunding continually increasing retiree medical costs.

The Trust is highly tax-favored: The contributions are made with pre-tax dollars; the Trust earnings are not taxable; and when you begin receiving benefits in the future, they will not be taxed (unlike pension payments that are taxed).

We, the Board of Trustees, are fellow public employees (firefighters, police officers, and deputy sheriffs), selected by the membership of our Associations. We are very pleased to distribute to you this Summary Plan Description ("SPD"), which provides general information regarding the operation of the Medical Expense Reimbursement Plan in a question-and-answer format, as well as summary of the rights and protections you are entitled to under federal law.

The Board of Trustees is totally committed to the successful operation of this Plan, with a goal of helping public sector employees and their families lessen the burden of retiree health costs. We welcome your input and comments.

Best Regards,

Board of Trustees
Central Valley Retiree Medical Trust

HIGHLIGHTS OF THE PLAN:

- Eligibility. Current employees will need 10 years in the Plan to achieve eligibility for benefits from the Trust. This requirement is 5 years for Employees who were employed when their Association joined the Trust. Employees also need to attain age 50.[1]

- Benefits. Your benefits from this Trust come in the form of reimbursement for Covered Expenses[2] (i.e., certain medical expenses[3] paid after you retire, limited to the amount of your monthly Benefit Level or the balance in your Individual Account).

- Claims. You must present your claims for monthly benefits to the Trust Office with your proof of payment of Covered Expenses, on a form approved by the Trustees, within 30 days after the end of the Plan Year in which the expense was paid or invoiced. Claims for expenses paid during the prior year must be received by the Trust Office on or before January 30th of the following year. **Note:** There is no claims deadline for claims reimbursed from your Individual Account.

- Change of Address, Spouse, or Dependent. If you move or have a change in mailing address, it is your responsibility to update the mailing address on file with the Trust Office. It is also your responsibility to update the information on file with the Trust Office if you have a change in spouse or children. Failure to notify the Trust Office may result in loss or delay of benefit payments or a fee charged for the costs of searching for your updated address.

- Trust Office. The Trust Office provides important services to the Trust. For example, to find out your Benefit Level, submit any benefit claims, request a copy of the Plan, or notify the Trust of a change in address, you may need to contact the Trust Office. The Trust Office may be contacted at the following address:

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
(213) 406-2367
centralvalley@bpabenefits.com
Trust website: www.centralvalleyrmt.org

Note: This SPD has been designed to provide you with key information about the Central Valley Retiree Medical Trust, but it does not provide all the details and limitations of the Plan. Exact specifications are provided in the Medical Expense Reimbursement Plan of the Central Valley Retiree Medical Trust, restated effective January 1, 2018, and as amended from time to time thereafter (the "Plan"). If there is a conflict between what is contained in the Plan and what is contained in this SPD or any other descriptions, the terms of the Plan will prevail.

[1] Age 55 for nonpublic safety employees.
[2] Capitalized terms are defined in the Plan.
[3] See Q&A 5 for a detailed description of what expenses are reimbursed.

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QUESTIONS AND ANSWERS (Q&A)

1. **Who can participate?**

Generally, participation in the Plan is required for all permanent employees, who are members of a bargaining unit represented by a participating Association, and for whom contributions are made to the Trust as required by a MOU.

2. **What is the difference between a Regular Beneficiary and a Limited Beneficiary?**

A Regular Beneficiary is eligible for a monthly benefit paid from the pooled account in the Trust. The Regular Beneficiary's monthly reimbursement cannot exceed his or her personal Benefit Level, which is calculated pursuant to a formula (see Q&A 7). Regular Beneficiary benefits are intended to last for the Regular Beneficiary's lifetime.[4] During employment, the Regular Beneficiary made payroll contributions into the pooled account in the Trust.

A Limited Beneficiary is eligible for monthly benefits paid from the Beneficiary's Individual Account in the Trust. The Limited Beneficiary's monthly reimbursement is limited by his or her account balance, and eligibility for benefits will terminate when the account balance reaches zero. Limited Beneficiary contributions to the Individual Account come from various sources: payroll contributions for members of bargaining units that are not participating in the pooled account; accrued leave transfers and other lump sum transfers at retirement; or roll over of pooled account contributions when the employee does not participate in the Plan for the minimum years to qualify for monthly benefits as a Regular Beneficiary. A Beneficiary can be both a Regular Beneficiary and a Limited Beneficiary.

At this time, Employees represented by the following Associations are not eligible for monthly benefits as a Regular Beneficiary, and instead have Contributions held in an Individual Account: Stanislaus County Deputy Sheriff's Association; Stanislaus County District Attorney Investigators Association; Stanislaus County Sworn Deputies Association; Stanislaus County Sheriff's Management Association; and Stanislaus County Sheriff's Supervisors Association. (See Q&A 4.)

3. **Who is eligible for monthly benefits as a Regular Beneficiary?**

An Employee becomes a Regular Beneficiary entitled to monthly benefits from the Pooled Account in the Plan after meeting the following requirements:

[4] The Plan is designed to provide benefits from the pooled account for the Eligible Retiree's lifetime. However, benefits are not vested or guaranteed. The Trustees have authority to increase, decrease or terminate benefits at any time for some or all current and/or future Beneficiaries.

- Earning 10 years of Active Service in the Trust (i.e., through 10 years of Contributions to the Trust and/or conversion of your Individual Account balance to equal 10 years of Active Service). However, if a person was already a participating Employee when his/her Association joined the Trust, the requirement is 5 years.

- Contributions are made to the Pooled Account on behalf of the Employee for all years of Active Service.

- Attaining age 50 if a sworn public safety employee, or age 55 for other public employees.

- Separating from all employment with a Participating Employer. (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. As of the date of this SPD, the Participating Employers are: County of Stanislaus, City of Modesto, and Stanislaus Consolidated Fire Protection District.)

4. **What happens if I separate from employment before contributing for the required years to become a Regular Beneficiary?**

If an Employee does not earn the required 5 or 10 years of Active Service necessary to become a Regular Beneficiary, that Employee is classified as a Limited Beneficiary. The Employee's Contributions will be held in Trust and credited to an Individual Account. The Employee becomes a Limited Beneficiary in this circumstance. The Limited Beneficiary may draw on that account for the reimbursement of Covered Expenses until the balance reaches zero. There is no monthly limit on the benefit for a Limited Beneficiary if all claims are for reimbursement of documented Covered Expenses. Benefits cease when the account balance reaches zero.

***Note:** Employees who have not earned the minimum Active Service from payroll Contributions during employment for monthly benefits have another option. Upon separation from employment, a former Employee can transfer the entire balance of his or her Individual Account into the Pooled Account to earn additional Active Service Units ("ASU"), and thereby attain the minimum Active Service for eligibility for a monthly benefit or increase his or her monthly Benefit Level. (See Q&A 9.)

5. **What are the eligibility requirements to become a Limited Beneficiary with benefits from an Individual Account?**

An Employee becomes a Limited Beneficiary entitled to benefits from an Individual Account after meeting the following two requirements. An individual can be both a Regular and Limited Beneficiary.

- Separation from employment with a Participating Employer. (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. As of the date of this SPD, the Participating Employers are: County of Stanislaus, City of Modesto, and Stanislaus Consolidated Fire Protection District.)

- A positive Individual Account balance due to one or more of the following events:

    - Transfers of accrued leave pursuant to a mandatory requirement in a MOU.
    - If an Employee contributes to the Pooled Account and fails to earn the required years of Active Service (see Q&A 3), credit for employee and employer contributions (including past investment gains/losses and a debit for administrative expenses).
    - Monthly contributions for members of Associations[5] participating in the Plan prior to March 12, 2008, subject to any change set forth in a MOU to which the Association is a party.

Credits and Debits to the Individual Account. The Trust Office will make the following credits and debits to your Individual Account monthly:

- Debits for a proportionate share of the Trust's operating expenses to administer the Plan.

- Credit, or debit, for a proportionate share of investment earnings, or losses, from the prior monthly period, if your Individual Account balance is greater than $100 on the first day of the quarter. If your Individual Account balance is equal to or less than $100, you will not receive an allocation of investment earnings or losses.

- Debits for claims payments.

- Debits for account closing fees. When a claim payment would cause your Individual Account balance to drop to $25 or less, the Trust Office will: (1) charge an account closing fee of $25 against your Individual Account balance before paying your final claim; (2) pay the remaining Individual Account balance, if any, to you as partial payment of your final claim; (3) close your Individual Account; and (4) prepare and send you the final Individual Account statement. For example, if your account balance is $40 and you submit a claim for reimbursement of $30 in Covered Expenses, then the Trust Office will first deduct the account closing fee of $25 from your account balance, which leaves $15 to make a partial payment of your final

[5] Stanislaus County Deputy Sheriff's Association; Stanislaus County District Attorney Investigators Association; Stanislaus County Sworn Deputies Association; Stanislaus County Sheriff's Management Association; and Stanislaus County Sheriff's Supervisors Association.

claim. The Trust Office will close your Individual Account and send you a claim payment of $15 and your final Individual Account statement.

There is no maximum amount on a claim from an Individual Account, if there is a sufficient balance in the Individual Account to cover the claim and the claim is properly submitted and documented. Benefits from an Individual Account terminate when the account balance reaches zero.

6. What are the benefits from the Plan?

After meeting the eligibility requirements, Beneficiaries are entitled to reimbursement of Covered Expenses, which consists of insurance premiums and medical expenses for services and supplies received after attaining eligibility. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment is limited to the Beneficiary's Benefit Level for Regular Beneficiaries and/or the balance in his/her Individual Account for Limited Beneficiaries.

Cost Sharing. It is important to remember that the Plan reimburses toward the cost of Covered Expenses, but your Benefit Level and/or Individual Account balance may not cover the entire Covered Expense amount. If your benefit payment does not cover the entire cost of your Covered Expense, you will be responsible for the balance of any Covered Expense amount owed in excess of your Benefit Level or Individual Account balance. (See Q&A 13 related to carryover of Covered Expense claims from month to month.)

7. What type of medical expenses will be reimbursed by the Plan?

The following items are considered Covered Expenses, and will be reimbursed by the Plan:

- Premium or contribution payments for coverage under health, dental, or vision insurance plans, which are excludible from gross income under Section 105(b) of the Internal Revenue Code of 1986, as amended (the "Code").

- Medical expenses excludable from gross income under Code Section 213(d) (i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury). Beneficiaries may refer to IRS Publication 502, or check with the Trust Office, to determine if a medical expense is a permissible reimbursement under the Plan.

- Premium payments for long-term care insurance to the extent qualified under Code Section 7702B.

All benefit payments from either the monthly Benefit Level or the Individual Account are subject to submission of a valid and documented claim for reimbursement of Covered Expenses.

8. How is my monthly Benefit Level from the Pooled Account calculated?

A Regular Beneficiary's monthly Benefit Level is determined by the number of Active Service Units he/she has accrued and the Unit Multiplier applicable to him/her. An Employee earns one Active Service Unit for each monthly Contribution of $50 to the Plan. After separation from employment, the Trust Office will calculate your monthly Benefit Level by the following methodology (as further described in Plan Section 3.3, and illustrated in Appendix A of the Plan):

- Determine the total number of Active Service Units.

- Multiply the total number of Active Service Units by the Unit Multiplier in effect on the date of your separation from employment with a Participating Employer.

From time to time, the Trustees will determine the Unit Multiplier, as defined in the Plan, with assistance of professional actuarial advice. On the date of publication of this SPD, the Unit Multiplier is $0.50 for Eligible Retirees who separated from employment on or after December 1, 2013.[6] For example, an Eligible Retiree who contributed $150 per month for 5 years would have 180 Active Service Units and would have a Benefit Level of $90 per month (180 x $0.50). You may contact the Trust Office to find out your total ASUs or the current Unit Multiplier.

The Trustees reserve the right to increase or decrease the Unit Multiplier for some or all current and/or future Eligible Retirees and Beneficiaries.

See Q&A 9 for information about converting your Individual Account balance to Active Service Units to attain eligibility for monthly benefits and/or increase your monthly Benefit Level.

9. **How do I earn Active Service? What is the difference between Active Service and Active Service Units or ASUs?**

An Employee may earn Active Service in the following ways:

- Monthly 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.

[6] The Unit Multiplier is $0.47 for Eligible Retirees who separated from employment on or after January 1, 2012, but before December 1, 2013.

- Conversion of Individual Account. (See Q&A 3.)

- Contribution After Ceasing Employment or Reduction of Hours. If your employment is terminated or reduced to less than full-time, you may continue to earn Active Service for a maximum of 18 months by making periodic self-payments to the Trust as permitted by the federal law known as COBRA,[7] and subject to rules set by the Trustees.

Note 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 is a factor in determining your monthly Benefit Level.

10. **Can I purchase additional Active Service Units to increase my Benefit Level and/or attain eligibility for monthly benefits?**

Yes, there are two ways to purchase Active Service Units that will increase your Benefit Level and can also help you attain the minimum years of Active Service for eligibility for monthly benefits. Those methods are as follows:

- COBRA Rights: After separating from employment with a Participating Employer (or experiencing a reduction of hours), which causes a cessation of Contributions on your behalf, you can purchase up to 18 months of Active Service by using your COBRA rights. When you cease employment and contributions to the Plan stop, you will receive a COBRA Notice from the Trust Office along with an Election Form to fill out and return to the Trust Office in order to start COBRA contributions to the Trust. Months of Active Service purchased through COBRA must be purchased at the same monthly contribution rate made by active employees in your bargaining unit. You will receive one ASU for each $50 contribution when making COBRA contributions. You can use your Individual Account funds to make COBRA contributions. There will be a box to check on the COBRA Election Form to direct the Trust Office to transfer funds from your Individual Account for this purpose. For more information about COBRA rights, please refer to the COBRA General Notice attached to this SPD.

- Conversion of Individual Account. Upon separation from employment, a former Employee can transfer the entire balance of his or her Individual Account into the

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

Pooled Account to earn additional ASUs, and thereby increase his or her monthly Benefit Level and/or earn the minimum Active Service for eligibility for the monthly benefit. The entire value of the Individual Account balance is converted to ASUs using an actuarial formula that considers your age at the time of conversion. Depending on your age at conversion, the cost of one ASU may be more than $50 (i.e., the cost may be more than the cost of one ASU during regular payroll contributions). You can request a copy of the Conversion Chart from the Trust Office. The Election Form for conversion is also available from the Trust Office. **Please Note:** this is an irrevocable election, and you cannot elect to transfer less than your entire Individual Account balance.

Pros and Cons of Conversion of Individual Account to Active Service Units (ASUs)

- *Monthly benefits last for lifetime whereas the Individual Account could run out.* The monthly benefits from the Pooled Account in the Plan are set with the intention for the monthly benefits to last for your lifetime.[8] Therefore, the Pooled Account monthly benefit could be helpful to you in budgeting your Plan benefits over your lifetime. In contrast, depending on how you manage the claims on your Individual Account, the Individual Account may run out during your lifetime.

- *Individual Account can pay for large expenses at once*. On the other hand, the Individual Account has no monthly limit on benefit payments and can be useful to pay for unexpected large medical expenses.

11. **Why is my Benefit Level different from other retirees in my Association? Why is my Benefit Level different from retirees in other Associations?**

The number of Active Service Units earned during an Employee's career will affect each Regular Beneficiary's monthly Benefit Level; thus, each monthly Benefit Level is personal to that Beneficiary. Therefore, Beneficiaries within the same bargaining group may have different monthly Benefit Levels, depending on how long they have contributed to the Plan. For example, at a Contribution rate of $150 per month, or 3 ASUs per month, an Employee will have 180 ASUs after 5 years or 216 ASUs after 6 years. Periods of leave without pay (i.e., without contributions) can also affect your number of ASUs.

The number of ASUs earned each month is also dependent on the bargained contribution rate in your MOU. For example, a monthly contribution rate of $150 will provide you three ASUs per month, but a monthly contribution rate of $200 will provide four ASUs

[8] 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. The monthly benefit payments are not guaranteed at a particular level; the Board of Trustees reserves the right to adjust the Unit Multiplier for calculating monthly Benefit Levels up or down at any time for some or all current and/or future Eligible Retirees and Beneficiaries.

per month. Thus, Beneficiaries from different bargaining groups may have different monthly Benefit Levels, depending on the contribution rate their respective bargaining groups selected and negotiated.

Adjustments to Benefit Level. The Trustees reserve the right and power to adjust the calculations for Benefit Levels at any time, which may cause your personal Benefit Level to increase or decrease. Such adjustments or termination of benefits may apply to some or all current and/or future Eligible Retirees and Beneficiaries.

12. **What benefits will my spouse and children receive in the event of my death?**

If an Eligible Retiree dies after attaining eligibility for benefits, then the Eligible Retiree's Surviving Spouse and Surviving Children will be eligible to continue receiving monthly benefits after the Eligible Retiree's death. A Surviving Spouse must have been the lawful spouse of the Eligible Retiree for at least 12 months prior to the date of death of the Eligible Retiree. Surviving Children include the natural and adopted children and stepchildren of the Eligible Retiree who are under the age of 26. Children over the age of 26 who were legally dependent on the Eligible Retiree and are determined to be totally disabled by the Social Security Administration are also eligible Surviving Children.[9]

If an Employee attains the applicable Active Service requirement for a monthly benefit but dies before attaining eligibility age, then the Employee's Surviving Spouse is eligible for benefits as a Regular Beneficiary.

Regular Beneficiary Benefit Levels for Survivors. The monthly Benefit Level for a Surviving Spouse with Surviving Children is equal to 100% of the Benefit Level of the deceased Eligible Retiree. However, the monthly Benefit Level for a Surviving Spouse without Surviving Children is equal to 50% of the Benefit Level of the deceased Eligible Retiree. If there is no Surviving Spouse, the monthly Benefit Level for the Surviving Children will be 50% of the Benefit Level of the deceased Eligible Retiree (to be divided among the Children).

Benefit Periods for Survivors of Regular Beneficiaries. Surviving Spouses are eligible for 24 months of benefits immediately following the death of the Eligible Retiree or Employee. If the Surviving Spouse is age 50 (or eligibility age applicable to the Eligible Retiree/Employee) at the end of the 24-month benefit period, then the Surviving Spouse's benefits will continue uninterrupted. If the Surviving Spouse is not yet age 50 at the end of the 24-month benefit period, then the Surviving Spouse's benefits are suspended until the Surviving Spouse attains age 50. When the Surviving Spouse attains age 50, benefit eligibility resumes.

[9] This same definition applies to Children for claims made by a living Eligible Retiree for Covered Expenses of a Child Beneficiary.

Surviving Children are eligible for benefit payments starting in the month following the death of the Eligible Retiree. A Surviving Child's benefit eligibility terminates on the Child's 26th birthday. Surviving Child benefits are not suspended when the Surviving Spouse benefits are suspended at the end of the 24-month benefit period, due to the Surviving Spouse being below age 50.

Limited Beneficiary Benefits for Survivors. If the deceased Eligible Retiree or Employee was or would have been eligible as a Limited Beneficiary, the Surviving Spouse and Surviving Children will have eligibility as Limited Beneficiaries eligible for benefits from the Individual Account balance following the Eligible Retiree's death.

All benefit payments from either the monthly Benefit Level or the Individual Account are subject to submission of a valid and documented claim for reimbursement of Covered Expenses.

Definition of Spouse. Spouse includes any lawful spouse. Note that the Trust grants the same rights and benefits to same-sex spouses as it grants to opposite sex spouses. If you have entered a same-sex marriage, please notify the Trust Office. 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.

13. **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. For example, if your 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 indefinitely until you use up the accumulated benefits).

14. **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 paid 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. All claim payment is subject to receipt of sufficient documentation of a qualified Covered Expense.

15. **How do I submit my claims for benefits?**

To present a claim for benefits under this Plan, the Eligible Retiree must submit a written claim, on a form supplied by the Trust Office, along with supporting documentation, to the Trust Office, c/o Benefit Programs Administration, using the following contact information:

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Website: www.centralvalleyrmt.org

Claim forms may be obtained by contacting the Trust Office or on the Trust website.

Claims Deadline. Claims must be received by the Trust Office within one month of the end of the calendar year in which the Beneficiary paid the Covered Expense or the date of a third-party invoice of the expense (i.e., on or before January 31st for Covered Expenses paid or invoiced in the prior calendar year). There are certain circumstances that the Trustees have determined to constitute good cause for waiver of the claims deadline. If you think you have good cause for missing the deadline, contact the Trust Office. This deadline applies to claims reimbursed from your monthly Benefit Level from the Pooled Account. There is no claims deadline for claims reimbursed from your Individual Account.

Documentation of Claims. The claim form must be accompanied by documentation from an independent third party that includes the following:

- The date that the medical service or supplies were provided or the dates of coverage for insurance premiums.
- A description of the medical service, supplies, or premiums.
- Proof of the Beneficiary's payment of the Covered Expense that 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 (including pension statement showing deduction for premiums).
  - Receipt for payment from the medical service, supplies, or insurance provider.
  - Other proof approved by the Board of Trustees.

For monthly insurance premiums, you must submit the above-referenced documentation upon request, but no less often than annually. If you do not submit the required documentation as requested, the Trust Office will suspend your benefit payments until the Trust Office receives proper documentation of your premiums.

Right to Submit Claims. The Eligible Retiree can submit claims for Covered Expenses of his or her legal spouse and Children (see definition of Spouse and Children in Q&A 12), but there is only one monthly Benefit Level for reimbursement of all Beneficiaries' claims. Therefore, only one Beneficiary has the right to submit claims, and the priority for that right is as follows: the Eligible Retiree has the right to submit claims during his or her lifetime, unless the Eligible Retiree delegates that right to his or her spouse in writing. After the death of the Eligible Retiree, the Surviving Spouse has the right to submit claims, unless the Surviving Spouse is ineligible for benefits (due to completion of the 24-months benefit period prior to attaining the eligibility age) (see Q&A 12). If the Surviving Spouse is under age 50 or there is no Surviving Spouse, then the Surviving Children have the right to submit claims.

In the circumstance that the Eligible Retiree delegates the authority to submit claims to his or her spouse or the Surviving Spouse delegates the authority to submit claims to his or her child, the family member would help submit claims to the Trust Office and sign the claim form on the Beneficiary's behalf, but the Trust Office will still pay all benefit payments to the Beneficiary. (See Q&A 20 related to prohibition of assignment of rights and claims.) You can contact the Trust Office to get a form for Delegation of Authority to Submit Claims. Please note that the signatures on the form must be notarized. The delegation can be revoked at any time by a written communication to the Trust Office.

Note that in the event 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.

16. **What are the appeal procedures for denied claims and other complaints?**

To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, 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. The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits.

Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial. You must exhaust the Plan's internal appeal procedures before filing an action in court.

17. **If my appeal is denied, is there a time limit for filing a lawsuit against the Trust for review of the denial?**

Yes. The time limit for a Beneficiary to bring action in federal court pursuant to ERISA Section 502(a) is no later than one year after the exhaustion of administrative remedies (i.e., the appeal process in Q&A 16), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint. 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.

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

The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse as a deduction applied to the benefit payments. The costs are deducted from benefit payments of the Eligible Retiree and ex-spouse and may vary from one divorce situation to another. The deduction from benefit payments may be spread amongst several months of benefit payments.

19. **What is the Plan Year?**

The Plan Year runs from January 1 to December 31.

20. **What should I do if I change my address or family composition?**

It is the Eligible Retiree's responsibility to notify the Trust Office of any change in mailing address or family composition (e.g., marriage, divorce, or birth or adoption of a child). Note that it is important to keep this type of information updated with the Trust Office so that notices related to the Plan and benefit payments may be sent to you and/or your Beneficiaries. Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan. In addition, the Trustees may charge a reasonable fee by deduction from your monthly benefits or Individual Account balance in order to recoup the costs to the Trust of finding missing participants. Please update the Trust Office with any changes to your address or Beneficiaries by contacting the following:

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
(213) 406-2367
centralvalley@bpabenefits.com
Trust website: www.centrralvalleyrmt.org

21. **What are the circumstances that may result in ineligibility or denial of benefits, or amendment or termination of the Plan?**

Circumstances that 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 documentation for claims, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note the following events will cause termination of benefits:

- An Eligible Retiree's benefits under this Plan will terminate upon his/her death, or if he/she returns to employment with a Participating Employer; provided, however, that benefits will resume after he/she ceases all employment with all Participating Employers. The suspension of benefits during reemployment applies to all benefits from the Plan, including both Individual Account benefits and monthly Pooled Account benefits.

- A Surviving Spouse's benefits under this Plan will terminate after 24 months of benefits have been paid following the Eligible Retiree's death; and benefits will resume in the month the Spouse attains the eligibility age for the deceased Eligible Retiree and terminate again on the Spouse's death.

- A Surviving Child's benefits under this Plan will terminate upon the loss of Child status, which is normally at age 26, or death of the Child.

- In addition to the above-referenced events, benefits from an Individual Account will terminate when the account balance reaches zero or there are no living Beneficiaries.

Benefit coverage and Benefit Levels may be modified or terminated pursuant to Article VI of the Plan and such changes may apply to some or all current and/or future Eligible Retirees and Beneficiaries. In the event of the termination of the Plan, assets of the Plan that remain after payment of expenses associated with termination will be allocated and distributed to the Beneficiaries in accordance with Code Section 501(c)(9).

22. **Can I assign 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 3.6. (There is an exception for incompetent Beneficiaries with a court-appointed representative. See Plan Section 3.6(g).)

23. **What are the names, telephone numbers, and addresses of the Trustees?**

Matthew Pettus, Chairman
Stanislaus Cty. Deputy Sheriff's Assoc.
P.O. Box 582445
Modesto, CA 95358
209.247.7132

Juan Alanis, Trustee
Stanislaus Cty. Sheriff's Supervisor Assoc.
250 E. Hackett Road
Modesto, CA 95358
209.652.1212

Jesse Miguel, Trustee
Modesto City Firefighters Assoc.
IAFF Local 1289
610 11th Street
Modesto, CA 95354
209.505.8981

Mike Avila, Trustee
Stanislaus Consolidated Fire Protection Dist.
3324 Topeka Street
Riverbank, CA 95367
209.605.9331

Gerard Hilgart, Trustee
Stanislaus County District Attorneys Investigators' Assoc.
832 12th Street, Suite 300
Modesto, CA 95354
209.986.7120

Tori Hughes, Trustee
Stanislaus County Sheriffs Managers' Assoc.
250 E. Hackett Road
Modesto, CA 95358
209.652.5600

Matthew Ponce, Trustee
Modesto Police Officers' Assoc.
600 10th Street
Modesto, CA 95354
209.402.1467

Vacant position
Stanislaus County Sworn Deputies Assoc.

24. **Is there any other information about this Plan that I should know?**

A. **Name of the Plan and Trust**

This Plan is known as the Fourth Restated Medical Expense Reimbursement Plan of the Central Valley Retiree Medical Trust, restated effective January 1, 2018, and as

amended from time to time thereafter. The Plan is governed by the Trust Agreement Governing the Central Valley Retiree Medical Trust, effective January 1, 2002, as amended thereafter (the "Trust Agreement"). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

B. **Name, Address, and Telephone Number of the Employee Organization That Established the Plan**

The Plan was originally established by the Stanislaus County Deputy Sheriff's' Association ("DSA"). The address and telephone number of the DSA are as follows:

Stanislaus County Deputy Sheriff's Association
P.O. Box 582445
Modesto, CA 95358
209.247.7132

Since that time, several other employee associations have joined the Trust.

C. **Identification Numbers of the Trust and the Plan**

The Employer Tax Identification Number (EIN) assigned to the Trust by the Internal Revenue Service is 81-6101173. The Plan number is 501.

D. **Type of Plan**

The Plan is a welfare benefit plan providing health insurance premium and medical expense reimbursement benefits to retirees. Beneficiaries may refer to Internal Revenue Publication 502 or check with the Trust Office to determine if a premium and/or medical expense is a permissible reimbursement under the Plan.

E. **Type of Administration/Trust Office Setup**

The Plan is administered by the Board of Trustees of the Central Valley Retiree Medical Trust. The Board has retained the services of a contract administrator to assist in recordkeeping, claims, payments, etc. The contact information of the Trust Office is:

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
(213) 406-2367
centralvalley@bpabenefits.com
Trust website: www.centralvalleyrmt.org

F. **Identity of the Plan Administrator**

The Plan Administrator (fiduciary) is the Board of Trustees of the Central Valley Retiree Medical Trust. They may also be contacted in care of the Trust.

G. **Existence of Bargaining Agreement That Addresses This Plan and Trust**

The Plan is maintained pursuant to a MOU between a Participating Employer and a Participating Association. Beneficiaries of the Plan (i.e., Employees, Eligible Retirees, Eligible Retirees' Spouses, Surviving Spouses, and Children), as defined in the Plan and Trust documents, may obtain copies of these MOUs upon written request to the Plan Administrator. Further, the MOUs are available for examination by Beneficiaries at the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing copies of a MOU. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

H. **Information Regarding the Family Medical Leave Act**

Please contact the Trust Office and/or your employer if you would like to take advantage of your right to self-pay contributions under the federal Family and Medical Leave Act ("FMLA"). For example, an Employee may be eligible to self-pay during FMLA leave for one of the following reasons (there are more 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.

I. **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. If you would like to take advantage of your rights under USERRA, contact the Trust Office for details. Regardless of whether or not 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 with a Participating Employer following your leave of absence.

J. **Information Regarding COBRA**

The General COBRA Notice is provided as an attachment to this SPD. If you have

misplaced the Notice and would like to request another copy, please contact the Trust Office. The General COBRA Notice is also available on the Trust website at www.centralvalleyrmt.org.

K. **Source of Contributions to the Trust**

Contributions to this Plan must be nonelective and are made by the Participating Employers, based on the MOU with the Participating Associations, and by employees. Further, under certain circumstances COBRA Beneficiaries may make self-payment contributions.

L. **Method Used for the Accumulation of Assets**

Contributions are received by and held in trust by the Trust and are invested with the assistance of a professional investment manager, utilizing investment policies and methods consistent with objectives of this Plan and ERISA requirements.

M. **Procedures for 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. Beneficiaries can obtain, without charge, a copy of such procedures and a copy of the model QDRO with their benefit information inserted, including the actuarially adjusted monthly Benefit Level of the ex-spouse of the Participant.

N. **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 on a Plan Trustee or the Trust Office at the address provided in Q&A 23E.

O. **Statement of Legal Rights**

- Rights of Plan Participants. Beneficiaries of the Central Valley Retiree Medical Trust are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

  Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing this Plan, including collective bargaining agreements, insurance contracts, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, and

available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this Summary Annual Report.

If there is a cessation of contributions to the Plan as a result of a COBRA qualifying event, you or your family members may elect to continue such contributions by self-payment. Review the General COBRA Notice and the Plan, Sections 2.2(c) and 2.2(d), for rules governing your COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations on the persons who are responsible for the operation of this employee welfare benefit plan.

  These persons who operate your Plan and Trust are called *fiduciaries* in the law. Fiduciaries must act solely in the interest of the Plan Beneficiaries and they must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to make good on any losses they have caused the Trust. No one, including an employer, may fire or otherwise discriminate against members to prevent them from obtaining a welfare benefit or exercising their rights under ERISA.

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

  Under ERISA there are steps that can be taken to enforce the above-mentioned rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that 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. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim to be frivolous.

- 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, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special precautions of health benefit plans to protect the privacy of *protected health information*. While providing benefits to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to 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, please contact the Trust Office (see Q&A 16(E)).

COBRA GENERAL NOTICE OF THE CENTRAL VALLEY RETIREE MEDICAL TRUST

IMPORTANT COBRA INFORMATION

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

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

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained in Section 2) would entitle the Qualified Beneficiary to reimbursement of a portion of your medical expense costs after retirement,[10] 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 Central Valley 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.[11]

   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

[10] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay reimbursement benefits to terminated Employees until retirement. The Plan accepts contributions during active employment, which are held by the Trust and will be used by Employees to purchase health coverage after retirement. In the event of the Employee's death, payments to the Surviving Spouse will commence the month after the Employee died for a 24-month period and resume in the month that the Surviving Spouse attains eligibility age.

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

AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

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

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 their benefits from the Plan in one of three ways:

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

(ii) The ability to augment their monthly post-retirement benefit, if the person had already met the eligibility requirement; and/or

(iii) The ability to augment the balance in the participant's Employee Account in the Plan.

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

B. Plan Eligibility Requirements. To be eligible to receive these medical expense reimbursement benefits after retirement, this Plan requires that the Employee earn 10 (or 5, if an Employee on the date that contributions to the Trust began for his/her bargaining unit) years of Active Service as defined in Section 2.2 of 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 amount if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your situation. If you choose to continue making contributions to this Plan, the

number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7**.

C. Consequence of Nonelection. If you do not choose to continue contributing to this Plan and have not earned 10 (or 5, as explained in 2B) years of Active Service, you will be eligible to receive benefits limited to the balance credited to your Individual Account.

D. Surviving Spouses and Children. Surviving Spouses and Surviving Children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in **Section 5** 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 for yourself (and your beneficiaries), 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 going on leave without contributions to the Plan.

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

B. The Spouse as a Qualified Beneficiary. If you are the **spouse of an Employee** covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Trust on your spouse's behalf cease due to any of the following Qualifying Events,[12] and provided that the Employee does not elect to self-pay contributions under COBRA*:

(i) Employee Spouse's Death. The death of the Employee;

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

[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.

(iii) Reduction of Employee Spouse's Work Hours. A reduction in the Employee spouse's hours of employment, including going on leave without contributions to the Plan; 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. A Child as a Qualified Beneficiary. If you are a **Child of an Employee** covered by this Plan, you may become a Qualified Beneficiary and have rights to self-pay contribution to this Plan if contributions to the Trust on your parent's behalf cease due to any of the following Qualifying Events, and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

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

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

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

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** must notify the Plan Administrator of the Qualifying Event.

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:

(i) Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan;

(ii) Divorce of the Employee and spouse;

(a) 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 18 months (or 29 months in the case of a disability, as described in **Section 6**);

(b) 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

(c) 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 for providing notice to the Trust Office for the occurrence of a second Qualifying Event, is **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**).

(ii) Qualifying Event of Disability. The period for providing notice to the Trust Office of a disability determination is **60 days after** the latest of the following events (but no later than the end of the first 18-month 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 for providing notice to the Trust Office of a change in disability is **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)**, a Qualified Beneficiary must provide written notice of the Qualifying Event(s), described in **Section 4(B)**, to the Trust Office by either first class mail or email. The contact information for the Trust Office is as follows:

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
Attn: Ms. Dora Vele
1200 Wilshire Blvd 5th Floor
Los Angeles, CA 90017
Email: centralvalley@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 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 36 months (3 years).

(iii) 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 18-month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to 18 months of self-payment contributions, for a maximum of 36 months. See **Sections 4(A)-(B) and 5** relating to notification requirements and procedure in the case of a second Qualifying Event.

(iv) 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 11 months, for a total of 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(A)-(B) and 5** relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional 11 months may be approximately 50% higher than the amount of the first 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—18, 29, or 36 months—for any of the following reasons:

   A. The Trust no longer maintains the Plan; or

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

   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 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 and/or phone number appearing below.

Central Valley Retiree Medical Trust
c/o Benefit Programs Administration
Attn: Ms. Dora Vele
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
Email: centralvalley@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**. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CENTRAL VALLEY RETIREE MEDICAL TRUST

NOTICE OF PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to information, called protected health information, that identifies a particular individual and relates to the past, present, or future physical or medical condition of the individual, provision of health care to the individual, or payment for the provision of health care to the individual. The Central Valley Retiree Medical Trust is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the way it may be used or disclosed.

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

I. **Our Duties Concerning Protected Health Information.** As the administrative agent for the Board of Trustees of the Trust, we are required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We are always also required to abide by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations about which you can obtain further information by contacting the Privacy Contact Officer identified in Section VII of this Notice.

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

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

A. For our payment of premium reimbursement claims. Payment includes but is not limited to actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to premium reimbursement.

B. For the payment activities of another covered entity or health care provider to whom we disclose the information. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. To another covered entity for health care fraud and abuse detection or compliance or health care operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains and information disclosed pertains to that relationship.

D. To disclose protected health information to the Board of Trustees of the Trust, as the plan fiduciary, as necessary for Trust administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

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

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

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

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

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

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

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

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

H. For research purposes where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of

protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

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

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

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

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

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

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

A. **Restrictions on Uses and Disclosures**. You may request that we restrict uses or disclosures of protected health information for the purposes of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care.

We are 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 otherwise described, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement with respect to protected health information created or received after we have notified you of the termination. Until then we will be required to abide by the restriction unless the information is required for purposes such as giving you emergency treatment; assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name

in a health care facility directory if you are incapacitated or in emergency circumstances; and circumstances described in Section III of this Notice in which an opportunity to agree or object need not be provided.

B. **Confidential Communications.** We must accommodate reasonable requests to have protected health information 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 protected health information could endanger you.

C. **Access for Inspection and Copying**: You may request access to inspect or copy protected health information 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 protected health information subject to your request.

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

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

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link

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

E. **Accountings of Disclosures**. You may obtain an accounting of our disclosures of protected health information about you during any period up to 6 years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same 12-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

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

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

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

A. **Privacy Contact Officer.** The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy

Contact Officer, whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice:

Privacy Contact Person
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
(213) 406-2367
centralvalley@bpabenefits.com

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

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

VIII. **Effective Date**: This notice shall become effective on the 1st day of October 2020, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI.

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

BOARD OF TRUSTEES
CENTRAL VALLEY RETIREE MEDICAL TRUST
Trust Office: (213) 406-2367