SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL EXPENSE REIMBURSMENT PLAN

OF THE

SOUTHERN CALIFORNIA PUBLIC SAFETY

RETIREE MEDICAL TRUST

ISSUED: February 2021

COBRA General Notice
and
HIPAA Privacy Practices Notice

Based on Medical Expense Reimbursement Plan, restated February 1, 2021

(Dr. 12/1/20 Incl. Plan Am. Nos. 1–15)

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San Diego, California 2021

Dear Participants in the Southern California Public Safety Retiree Medical Trust:

The Southern California Public Safety Retiree Medical Trust (the "Trust") was established by the Alhambra Police Officers Association ("APOA"). The Trust is an employee benefits trust designed to provide financial support during your retirement, in the form of reimbursement toward retiree medical costs. Your Association has negotiated an employer contribution into this Trust; specific language can be found in your Memorandum of Understanding ("MOU"). By negotiating a contribution to the Medical Expense Reimbursement Plan of the Southern California Public Safety Retiree Medical Trust (the "Plan"), your Association is proactively planning for your retirement by prefunding the continually increasing medical expenses of retirees.

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

We, the Board of Trustees, are fellow police officers, selected by the membership of the APOA. We are very pleased to distribute to you this Summary Plan Description, which provides general information regarding the operation of the Plan in a question and answer format, a brief summary of the Plan, and rights and protections to which you are entitled under federal law.

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

Best Regards,

Board of Trustees
Southern California Public Safety Retiree Medical Trust
February 2021

HIGHLIGHTS OF THE PLAN

Eligibility. Generally, current Employees will need 7 years in the Plan to achieve eligibility for reimbursement benefits from the Trust. A minimum Benefit Level[1] is available to Employees employed on July 1, 2005, who did not participate in the Plan for 7 years prior to retirement.

Benefits. Your benefits from this Trust come in the form of reimbursement for certain medical costs, which are considered Covered Expenses[2] and incurred after you retire. Your reimbursement is limited to the amount of your monthly Benefit Level, which will vary by Employee and depends on your years of Active Service in the Plan. Note that your monthly Benefit Level is reduced by 25% upon Medicare eligibility. Contact the Trust Office to find out your Benefit Level.

Claims. You must present your claims to the Trust Office with your proof of Covered Expense payment, on a form approved by the Trustees, within 3 months from the end of the plan year in which you paid for the Covered Expense. The Plan Year ends on January 31st; claims for payments made during the prior Plan Year are due no later than April 30th each year. However, you are encouraged to submit your claims throughout the Plan Year.

Change of Address, Spouse, or Children. 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 get divorced or married or a new child is born or adopted. Failure to notify the Trust Office may result in loss or delay of benefit payments.

Trust Office (Administrator). The Trust Office provides important services to the Trust. 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 may contact the Trust Office at:

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com
www.scpublicsafety.com

Important Information–Please Read:
This Summary Plan Description ("SPD") has been designed to provide you with key information about the Trust, but it does not provide all the details and limitations of the Plan. Exact specifications are provided in the Medical Expense Reimbursement Plan, restated effective February 1, 2021 (Dr. 12/7/20), and as amended from time to time thereafter (the "Plan"). If there is a conflict between the Plan and what is contained in this Summary Plan Description or any other description, the terms of the Plan will prevail.

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[1] Capitalized terms contained herein are defined in the Plan.
[2] See Q&A 4 for a detailed description of the type of expenses for which you may be reimbursed.

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1. Who is a Plan participant?

All full time Employees, employed on or after July 1, 2005, who are represented by the APOA, and for whom the Trust has received mandatory Contributions pursuant to a MOU during the Employee's employment, participate in the Plan. Employees who promoted out of the APOA after July 1, 2005, and on whom the Trust has received mandatory Contributions following promotion, also participate in the Plan and receive Active Service for each month of Contributions received.

2. Who is eligible for benefits?

An Employee described in Q&A 1 becomes eligible for benefits under the Plan, generally, after the Employee meets all the following requirements:

- Earns 7 years of Active Service (i.e., 7 years of Contributions to the Trust during employment);
- Contributions are made to the Trust for all years of Active Service;
- Attains age 50 if hired before July 1, 2013, or age 57 if hired on or after July 1, 2013; and
- Separates from all employment with the City of Alhambra (the "City"). (Return to any employment with the City 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 the City.)

Special Eligibility Provisions:

- *Employee represented by the APOA on July 1, 2005.* An individual who was both an Employee and represented by the APOA on July 1, 2005, and had contributions made to the Trust on his or her behalf pursuant to a MOU in effect on that date, shall be an Eligible Retiree when he or she attains the applicable eligibility age (currently 50) and separates from employment with the City of Alhambra (regardless of whether he or she earned 7 years of Active Service).
- *Calculating Active Service for Initial Plan Participants.* The City started making contributions for the Trust on July 1, 2005, and transferred those contributions to the Trust upon its establishment on February 1, 2006. Individuals employed on July 1, 2005, started earning Active Service on July 1, 2005, prior to the Trust effective date.

- *Employees permanently disabled in the line of duty*. If an Employee becomes permanently disabled in the line of duty and submits written proof to the Trust Office from the State of California Division of Workers' Compensation of a work-related, permanent disability rating of 40% or more, then that Employee shall be an Eligible Retiree without meeting the above eligibility requirements. However, these early benefits are limited in amount and duration until the Eligible Retiree meets the applicable eligibility age. For more information about individuals disabled in the line of duty, please see Q&A 6.

Eligibility of Spouse and Children:

- An Eligible Retiree has the right to submit claims for the Covered Expenses of his or her legal spouse and Children, but there is only one monthly Benefit Level for reimbursement of all Beneficiaries' expenses.

- Spouse includes any lawful spouse. The Trust grants the same rights and benefits to same-sex spouses as it grants to opposite-sex spouses. Please keep the Trust Office notified of your marital status and current spouse.

- Child includes the natural or adopted child of the Eligible Retiree or Employee, the stepchild of the Eligible Retiree or Employee, and a foster child placed with the Employee or Eligible Retiree by an authorized placement agency or by court order. Children are only eligible for benefits under age 26, unless the Child is legally dependent upon the Eligible Retiree or Employee and is determined to be totally disabled by the Social Security Administration.

- The Surviving Spouse and Surviving Children of an Employee who has attained the Active Service eligibility requirements above, but dies before attaining the eligibility age, is still eligible for survivor benefits.

3. What are the medical reimbursement benefits?

After meeting the eligibility requirements, Beneficiaries are entitled to reimbursement toward the payment of Covered Expenses, which consists of insurance premiums and medical expenses incurred on or 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 Eligible Retiree's monthly Benefit Level (See Q&A 5).

Cost Sharing. It is important to remember that the Plan reimburses toward the cost of Covered Expenses, but your Benefit Level 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 balance of any Covered Expense amounts in excess of your

Benefit Level. Further, your reimbursement amount cannot exceed the actual amount of your out-of-pocket expense.

4. What types of medical expenses will the Plan reimburse?

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

- Premium or contribution payments to health, dental, or vision insurance plans, for coverage in effect while the Beneficiary is eligible for benefits and for types of medical expenses excludible from gross income under Section 105(b) of the Internal Revenue Code of 1986, as amended (the "Code").

- Medical expense excludable from gross income under Code Section 213(d) (i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury) for medical services or supplies, including insulin but excluding all other nonprescribed drugs, provided while the Beneficiary is eligible for benefits.

5. How is my individual Benefit Level calculated?

The Benefit Amount is the monthly maximum amount available for the reimbursement of Covered Expenses, as determined by the Trustees from time to time. Your Benefit Level is a percentage of the Benefit Amount based on the number of Active Service years you have earned. You need 12 years of Active Service in the Plan to have a Benefit Level equal to 100% of the Benefit Amount. The individual Benefit Level for an Eligible Retiree is determined by multiplying the current Benefit Amount ($1,075 on the date of this publication) by the Percentage of Benefit Amount for your years of Active Service (see table below).

YEARS OF ACTIVE SERVICE	PERCENTAGE OF BENEFIT AMOUNT
Less than 7	0%
7	58.3%
8	66.7%
9	75.0%
10	83.3%
11	91.7%
12	100%

For example, at the current Benefit Amount of $1,075, if an Employee retires in 2021 after earning 9 years of Active Service and meeting all the eligibility requirements, that Employee would be entitled to 75% of the Benefit Amount, and his/her individual monthly Benefit Level would equal $806.25 (i.e., $1,075 x 0.75).

- ***Minimum Benefit Amount.*** Appendix A to the Plan provides the current Minimum Benefit Amount. The Minimum Benefit Amount is used to calculate a Beneficiary's Benefit Level in the following circumstances:

  (1) **Eligible Retiree Employed on July 1, 2005, without 7 Years of Active Service.** If an Employee was employed by the City and a member of the bargaining unit represented by the APOA on July 1, 2005, and the City made contributions to the Trust on the Employee's behalf, then the Employee is an Eligible Retiree regardless of whether he or she had 7 years of Active Service in the Trust. If the Employee did not have 7 years of Active Service, then he or she will have a Benefit Level equal to the Minimum Benefit Amount (currently $626.73). If the Employee had 7 or more years of Active Service, then he or she will have a Benefit Level calculated as a Percentage of the Benefit Amount (see table above).

  (2) **Disabled Eligible Retiree without 7 Years of Active Service.** An Employee who meets the Plan requirements for a disabled Eligible Retiree (see Q&A 2 for qualification requirements) will be an Eligible Retiree regardless of whether he or she had 7 years of Active Service in the Trust. If the disabled Eligible Retiree did not have 7 years of Active Service, then he or she will have a Benefit Level equal to the Minimum Benefit Amount (currently $626.73). If the disabled Eligible Retiree had 7 or more years of Active Service, then he or she will have a Benefit Level calculated as a Percentage of the Benefit Amount (see table above). If the disabled Eligible Retiree has not yet attained the eligibility age (50 or 57, as applicable), then the disabled Eligible Retiree will be entitled to only 50% of his/her Benefit Level for 24 consecutive months after separation from City employment. Benefit payments are then suspended until the disabled Eligible Retiree attains the eligibility age. When the disabled Eligible Retiree attains the eligibility age (50 or 57, as applicable), the disabled Eligible Retiree is entitled to 100% of his/her Benefit Level.

  The disabled Eligible Retiree has the right to select the 24-month period for benefits, which must occur between his/her documented disability date and attaining eligibility age (50th or 57th birthday, as applicable). The 24-month period will start when the Trust Office receives a claim for benefits. **If the Eligible Retiree does not submit a claim to start the 24-month period, then this benefit period is forfeited upon expiration of the claim deadline for that plan year.**

  (3) **Survivors of Employees Who Die in the Line of Duty.** If an Employee dies in the line of duty,[3] then the Benefit Level of the Surviving Spouse and Children is calculated based on the deceased Employee's Benefit Level on the date of his/her death (see table above). If the Employee did not have 7 years of Active Service on the date of death, then the deceased Employee's Benefit Level is equal to the

[3] See Q&A 7 for qualification requirements for death in line of duty.

Minimum Benefit Amount (currently $626.73). Prior to the date that the Employee would have attained the applicable eligibility age (i.e., the deceased Employee's 50th or 57th birthday), the Surviving Spouse and Children will have a joint Benefit Level equal to 50% of the deceased Employee's Benefit Level. On the date that the Employee would have attained the eligibility age, the Surviving Spouse and Children's Benefit Level is increased to 100% of the deceased Employee's Benefit Level. There is one monthly Benefit Level for all survivors.

- ***Benefit Level Reduction at Medicare Eligibility.*** The Eligible Retiree's Benefit Level is reduced by 25% when he/she becomes eligible for Medicare. A Surviving Spouse or Surviving Child's Benefit Level is reduced by 25% when the Eligible Retiree would have become eligible for Medicare if living; the Medicare Eligibility of the Surviving Spouse has no effect on the Benefit Level. The Trust Office assumes that the Eligible Retiree is Medicare eligible when he or she reaches the Medicare Eligibility age (currently age 65). If you are not eligible for Medicare, you must submit proof of ineligibility to the Trust Office in order to continue receiving your full Benefit Level without reduction after Medicare Eligibility age. This reduction at Medicare Eligibility applies to all Eligible Retirees and Survivors, regardless of the circumstances surrounding their eligibility. For example, the reduction applies to the Benefit Level of survivors of Employees who die in the line of duty and disabled Eligible Retirees and their survivors.

6. What will my benefit be if I become disabled in the line of duty?

- ***Benefit Level.*** A Disabled Eligible Retiree, who has not reached the regular eligibility age, may receive 50% of his or her Benefit Level as of the date that he or she separated employment for a period of 24 months, as explained further below.[4]

  If a Disabled Eligible Retiree has not earned the minimum Active Service (currently 7 years), then the disabled Eligible Retiree's Benefit Level is equal to the Minimum Benefit Amount (currently $626.73). Disabled Eligible Retirees, who have attained the regular eligibility age and have earned the minimum Active Service, will receive benefits without regard to disability.

- ***Benefit Period.*** A Disabled Eligible Retiree is eligible for reimbursement benefits at 50% of his/her Benefit Level for a 24-month period following the date of written proof of disability. The disabled Eligible Retire can choose any 24-month period between the date of disability and his/her 50th birthday (or 57th birthday for Employees hired on or after July 1, 2013). The 24-month benefit period will start when the disabled Eligible

[4] The date of separated employment is defined in the Plan as the "effective date of this transaction" on the City of Alhambra Personnel Action form.

Retiree submits his or her first claim to the Trust Office.[5] **After 24 months of benefit eligibility, the disabled Eligible Retiree's benefits are suspended until he or she reaches the regular eligibility age under Plan Section 2.1(b).** At regular eligibility age, the disabled Eligible Retiree is entitled to reimbursement benefits at 100% of his/her Benefit Level (until Medicare eligibility when the Benefit Level for all Eligible Retirees is reduced by 25%).

- ***Example.*** Employee A has been participating in the Trust for 10 years and became permanently disabled in the line of duty and separated from employment on January 1, 2021, at the age of 43. Employee A received a permanent disability rating of 50% from the Division of Workers Compensation, dated April 1, 2021, and submitted that document to the Trust Office. Employee A is eligible for benefits starting on April 1, 2021, at 50% of his Benefit Level effective as of January 1, 2021 (separation from employment date), which is calculated as follows:

  Step 1: Calculate regular Benefit Level for 10 years of Active Service:
  83.3% of $1,075 (Benefit Amount) = $895.48

  Step 2: Calculate early Benefit Level for disabled Eligible Retiree:
  50% of $771.03 = $447.74

  If the disabled Eligible Retiree chooses to start benefit payments on January 1, 2021,[6] then on January 1, 2023, this disabled Eligible Retiree's benefits will be suspended until he reaches age 50 in 2028. When he reaches the regular eligibility age in 2028 (age 50 because he was hired prior to July 1, 2013), his benefits will restart at $895.48 per month (100% of his/her Benefit Level).[7] At Medicare eligibility, his/her benefits will go back to 50% of his/her Benefit Level, or $358.52 per month.

7. How is the Benefit Level calculated for my Surviving Spouse and Children in the event of my death?

A Surviving Spouse is eligible to receive up to 50% of the Benefit Level of the deceased Eligible Retiree, beginning on the later of the date of death or the date the deceased Eligible Retiree would have been eligible for benefits, and lasting until the Surviving Spouse's death. The Trust Office will request proof of marriage before starting payment of surviving spouse benefits. If the Eligible Retiree had not yet become eligible for Medicare on the

[5] The Eligible Retiree has the responsibility to select this period. If the Eligible Retiree does not submit a claim to start the 24-month period, then this benefit period is forfeited upon expiration of the claim deadline for that plan year.

[6] If the disabled Eligible Retiree does not need the benefits right away (e.g., a spouse has coverage for the disabled Eligible Retiree), then the retiree may decide to wait start the 24 months of benefit payments.

[7] Employee A was working at Alhambra and represented by the APOA before July 1, 2013. If the Employee was hired on or after July 1, 2013, then the Employee would have to wait unit age 57 to receive 100% of his Benefit Level. If the Employee did not have 7 years of Active Service, then his Benefit Level would be the Minimum Benefit Amount).

date of his or her death, then the Surviving Spouse's benefits will be reduced by 25% on the date that the Eligible Retiree would have attained Medicare Eligibility. For example, if the Eligible Retiree's Benefit Level was $1,075 at the time of his death at age 57, then the Surviving Spouse will receive $537.50 per month until the date that the Eligible Retiree would have attained Medicare eligibility. On that date, the Surviving Spouse's benefit will reduce to $403.13 per month.

Surviving Children are only eligible for benefits until they reach age 26, as defined in the Plan (with limited exception). A Surviving Spouse can submit claims for Covered Expenses of Surviving Children, up to the shared Benefit Level for the Surviving Spouse, as long as Surviving Children are eligible.

If there is no Surviving Spouse, then any Surviving Children are eligible to share 100% of the Benefit Level of the deceased Eligible Retiree, as long as the Children continue to meet the eligibility requirements (i.e., generally under age 26).

Eligible Surviving Children may also continue to receive benefits, until they lose eligibility, in the event of the deaths of both an Eligible Retiree and a Surviving Spouse, beginning the month after the Surviving Spouse's death or the month after the Eligible Retiree's death, whichever is later.

- ***Special provision for Spouses of Employees who die in the line of duty.*** Beginning immediately upon the Employee's death in the line of duty (as determined by the California Division of Workers' Compensation), the Surviving Spouse and/or Children will receive 50% of the Benefit Level of the deceased Employee, regardless of whether that Employee was eligible for benefits at the time of death. Further, on the date that the deceased Employee would have attained the eligibility age of 50 or 57, the Surviving Spouse and Children will receive 100% of the Benefit Level of the deceased Eligible Retiree. Like all other Surviving Spouse benefits, these Surviving Spouse benefits are reduced by 25% on the date that the deceased Employee would have attained Medicare eligibility. Surviving Children are eligible for benefits until they reach age 26, with limited exception, as explained in the Plan. After the Trust Office receives proof of line of duty death, survivor benefit payments are paid retroactive to the month following the date of death, provided that the Trust Office receives documented, valid claims for Covered Expenses paid by the surviving Beneficiaries in each of these months.

8. Are there benefits for my Domestic Partner in the event of my death?

No, due to the cost of compliance with federal tax regulations and the required taxation of domestic partner benefits, the Plan does <u>not</u> provide benefits for domestic partners or surviving domestic partners. However, spouse includes any lawful spouse (same or opposite sex). Note that the Trust grants the same rights and benefits to same sex spouses

as it grants to opposite sex spouses. If you are married, please contact the Trust Office to put your spouse's information on file for future benefits.

9. How do I submit my claims for benefits?

To present a claim for benefits under this Plan, Beneficiaries must submit a written claim, on a form approved by the Trustees, along with supporting documentation to the Trust Office at:

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com

Claims must be received by the Trust Office within 3 months after the end of the Plan Year in which the Beneficiary paid the Covered Expense. The Plan Year ends on January 31st, so any remaining claims for Covered Expenses that you paid for in the prior 12 months are due to the Trust Office no later than April 30th each year. The Trust encourages you to submit claims and receive reimbursements throughout the Plan Year, but you have until April 30th to submit any claims that were not previously submitted for the prior 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.

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

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

For monthly insurance premiums, you must submit the above 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.

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.

Only one Beneficiary has the right to submit claims, and the priority for that right is as follows. The Eligible Retiree must submit the claims for benefits for his/her own Covered Expenses and the Covered Expenses of his/her Beneficiaries. After the Eligible Retiree's death, the Surviving Spouse must submit the claims for reimbursement of Covered Expenses for him/herself and the Surviving Children. If the Surviving Spouse is not currently eligible for benefit payments (due to the requirement to wait until the deceased Employee's 50th or 57th birthday) or if there is no Surviving Spouse, then the Surviving Children or their legal guardian may submit claims. Beneficiaries can also authorize a family member to submit claims on their behalf. In this circumstance, the family member would help the Eligible Retiree or Surviving Spouse to submit claims to the Trust Office and sign the claims form on their behalf, but the Trust Office will still pay all benefit payments to the Beneficiary. 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.

Beneficiaries 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.

10. 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/her position and any evidence in support of his/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. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

11. What happens if I have an expense that exceeds my monthly Benefit Level or I do not use my full Benefit Level in one month?

If a Beneficiary submits a claim for a Covered Expense that is greater than his/her monthly Benefit Level, then the excess will be carried over and paid in subsequent months, up to his/her monthly Benefit Level, as long as the total claim payments during a Plan Year do not exceed his/her annual Benefit Level. However, any unused balance of his/her monthly Benefit Level will not be carried over to the next month. For example, if an Eligible Retiree with a monthly Benefit Level of $1,075 submits a claim for a Covered Expense of $900, which was paid in January, the Plan will reimburse him for $900. There is no carryover of the unclaimed $175 to February. To receive the remaining $175 Benefit Level from January, the Eligible Retiree must submit another Covered Expense that he/she paid in January.

12. Is there a time limit for filing a lawsuit against the Trust for benefit payments, etc.?

Yes, there is a limitation period for filing a lawsuit against the Trust for benefit payments, etc. The time limit for a Beneficiary to bring action in federal court, pursuant to Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), is not later than one year after the exhaustion of administrative remedies (i.e., the appeal process mentioned above), 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. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

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

The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the Beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse. The Trust Office will deduct the QDRO fee from your benefit payments and may spread the QDRO fee deduction across several benefit payments. The costs include, but are not limited to, the following, and may vary from one divorce situation to another:

- 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.

14. What is the Plan Year?

The Plan Year runs from February 1 to January 31.

15. What should I do if I change my address, spouse, or children?

It is the Participant's responsibility to notify the Trust Office of any change in mailing address, spouse, or children. 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.** The Trustees may charge a reasonable fee by deduction from your monthly benefits 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:

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com

16. What are the circumstances that may result in ineligibility, suspension, 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 expense receipts, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note that the following events will cause termination 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 the City; provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with the City.

- A *disabled Eligible Retiree's* benefits under this Plan will be suspended 24 months after the start date of the early 50% disability Benefit Level and then restarted at regular eligibility age. A disabled Eligible Retiree's benefits under this Plan are also suspended upon return to employment with the City.

- A *Surviving Spouse's* benefits under this Plan will terminate upon his/her death.

- A *Surviving Child's* benefits under this Plan will terminate upon the loss of Child status. However, if the Child was determined (prior to the death of the Eligible Retiree) to be totally disabled by the Social Security Administration and the Child was legally dependent upon the Eligible Retiree at the time of the Eligible Retiree's death, then the Child is entitled to benefits under this plan as long as the Child continues to be totally disabled.

The individual Benefit Level and Benefit Amount 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 Beneficiaries. In the event of 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).

17. 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. (There is an exception for incompetent Beneficiaries with a court-appointed representative.)

18. What are the names and addresses of the Trustees?

Trustees: Debbie Gomez (Chairperson)
Bob Torrance (Vice Chairperson)
Joey Wilson (Secretary)
Russell Rongavilla
Carlos Donato

Address: Board of Trustees
Southern California Public Safety Retiree Medical Trust
c/o Alhambra Police Officers' Association
P.O. Box 7339
Alhambra, CA 91802

Police Management Association Liaison: Eddie Elizalde

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

A. The name of the Plan and Trust.

This Plan is known as the Medical Expense Reimbursement Plan of the Southern California Public Safety Retiree Medical Trust, restated February 1, 2021, and as amended from time to time thereafter (the "Plan"). The Plan is funded through the Southern California Public Safety Retiree Medical Trust (the "Trust"), which is governed by the Trust Agreement Governing the Southern California Public Safety Retiree Medical Trust, effective February 1, 2006, and as amended form time to time thereafter (the "Trust Agreement'). For a copy of the Plan or Trust Agreement, contact the Trust Office.

B. The name and address of the employee organization that established this Plan.

The Plan was established by the APOA whose address is:

Alhambra Police Officers' Association
211 First Street
Alhambra, CA 91801

C. The identification numbers of the Plan and Trust.

The Employer Tax Identification Number (EIN) assigned to the Trust by the Internal Revenue Service is 20-6815931.

The Plan number is 501.

D. The 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 Service 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. The type of administration/trust office.

The Plan is administered by the Board of Trustees of the Southern California Public Safety 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:

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com

F. The identity of the Plan Administrator.

The fiduciary of the Plan (known under federal law as the *Plan Administrator*) is the Board of Trustees of Southern California Public Safety 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 of Trustees in care of the Trust Office.

G. The existence of a bargaining agreement that addresses this Plan and Trust.

The Plan is maintained pursuant to a document entitled *Memorandum of Understanding Between the City of Alhambra and the Alhambra Police Officers' Association for Fiscal Years 2019 through 2021* ("MOU") and applicable successor agreements. The terms of the MOU require that the City make Contributions to the Trust on behalf of covered Employees.

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

H. Family Medical Leave Act (FMLA).

Please contact the Trust Office and/or your Employer if you would like to learn more about the right to self-pay contributions during FMLA leave authorized by your Employer. An Employee may be authorized to take FMLA leave for reasons described in the FMLA law, including 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; or

- To take medical leave when the Employee is unable to work because of a serious health condition.

If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-contributions. Please contact the Trust Office for more information if this situation applies to you.

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 City employment following your leave of absence.

J. 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 document. Also, if you would like to request a copy of the General COBRA Notice, please contact the Trust Office.

K. The source of contributions to the Trust.

Contributions to the Plan are made by the City of Alhambra based on the MOU between the APOA and the City. Under special circumstances (e.g., COBRA), former Employees and Beneficiaries may make self-pay contributions.

L. The method that is 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 QDROs and QMCSOs.

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 for QDROs and QMCSOs and a model QDRO for this purpose. Beneficiaries can obtain from the Trust Office, without charge, a written explanation 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.

N. 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. See address in Q&A 14(E).

O. Statement of legal rights.

- Rights of Plan Participants. Beneficiaries of the Southern California Public Safety Retiree Medical Trust are entitled to certain rights and protection under ERISA. ERISA 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 contacts and 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 contacts, collective bargaining agreements, a copy of the latest annual report, and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

  Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each 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 dependents may have the right to continue such contributions by self-pay. Review the General COBRA Notice and the Plan, Section 2.2(b) and 2.2(c), for rules governing your COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations upon 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 rights. For instance, if you request a copy of Plan documents or the latest annual report for 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 the Plan 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 form the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration at 866.444.3272.

- 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 (PHI). In the course of providing benefits to you under this Plan, the Trust Office may acquire PHI. Accordingly, the Plan has developed procedures to restrict access to PHI 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.

COBRA GENERAL NOTICE

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 attaining the eligibility age. This Plan gives the Employee (or family member) the right to self-pay contributions into the Trust, which were formerly paid pursuant to a collective bargaining agreement or other special agreement while the Employee was working. If you have questions regarding the eligibility requirements under the Plan or are in doubt about the application of COBRA under this Plan, please contact the Trust Office.

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of your health premium or medical expense costs after termination, resignation or retirement from the City of Alhambra and attainment of the eligibility age (currently 50 or 57 depending on your date of hire),[8] rather than health benefits insurance coverage for former Employees of any age. That is, this Plan is intended for retiree reimbursement health benefits, not insurance coverage.

1. **COBRA Generally.** You are a participant in the Retiree Medical Expense Reimbursement Plan (hereafter the "Plan") of the Southern California Public Safety Retiree Medical Trust (hereafter the "Trust"), which provides reimbursement towards certain health premiums and medical expenses as defined in the Plan, after reaching the eligibility age and other eligibility requirements. 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.[9]

   THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAY CONTRIBUTIONS UNDER

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[8] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health insurance coverage immediately following loss of employment. In contrast, this Plan does not pay reimbursements for premiums or medical expenses to terminated Employees until retirement and attainment of age 50 or 57, as applicable. The Plan accepts contributions during active employment, which are held by the Trust and will be used by Employees to reimburse premiums and medical expenses after retirement.
[9] Public Law 99-272, Title X.

COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAY CONTRIBUTIONS. 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.

A. Application of COBRA to This Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Trust through self-pay contributions, 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[10] monthly reimbursement benefit from the Plan, which he/she may not otherwise have been able to meet (see **Section 2(B)** below); and/or

ii) To augment their monthly post-retirement benefit, if the person had already satisfied minimum eligibility requirements.

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 health premium and medical expense reimbursement benefits after attaining eligibility age, this Plan requires that the Employee earn at least 7 years of Active Service, as defined in Section 2.2 of the Plan. Therefore, making COBRA self-pay contributions could make you eligible, depending on how many years of Active Service you have earned at the time of the Qualifying Event.

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

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[10] 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.

C. Consequence of Nonelection. If you choose not to continue contributing to this Plan and you have not earned 7 years of Active Service, you will receive no benefits from the Plan and will forfeit all Active Service earned under this Plan.

D. Surviving Spouses and Children. Surviving Spouses and Children may also have the right to continue self-pay contributions under certain circumstances. Contact the Trust Office at the address in Section 5 below for details.

3. Qualifying Events and Qualified Beneficiaries.

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

B. 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,"[11] and provided that the Employee does not elect to self-pay contributions under COBRA*:

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

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

iii) Reduction of Employee 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.

[11] 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.

*__Note:__ Only one member of a family may make self-pay 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-pay contributions. This means that only one Qualified Beneficiary can self-pay.

C. Child as a Qualified Beneficiary. If you are a child of an Employee covered by this Plan, you may become a Qualified Beneficiary and may 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; or

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 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) Divorce of the Employee and spouse;

ii) 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 below);

iii) 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-pay contributions; or

iv) 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 of a 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 below).

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-pay 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) 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:

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com
www.scpublicsafety.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 thirty (30) days following the first of the month. **You will not receive monthly reminders that payment is due**.

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-pay 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-pay contributions 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 18-month period of self-pay contributions, the Plan beneficiaries may be eligible to receive an extension of up to 18 months of self-pay contributions, for a maximum of 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 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-pay contributions and must last at least until the end of the 18-month period of self-pay 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 11 months may be approximately 50% higher than the amount of the first 18 months if the self-pay contributions include a disabled beneficiary and the extension of period for self-pay 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-pay contribution period—18, 29, or 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 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-pay contribution rights, you should contact the Trust Office at the address and/or phone number appearing below.

Southern California Public Safety Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
833.504.3967
scpublicsafety@bpabenefits.com
www.scpublicsafety.com

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

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

NOTICE OF PRIVACY PRACTICES

WITH RESPECT TO PROTECTED HEALTH INFORMATION

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 Southern California Public Safety 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 manner in which it may be used or disclosed.

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

I. Our Duties Concerning Protected Health Information. 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 also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations 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. Deidentified 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 above will be made only with your written authorization. You may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or the policy itself.

V. Individual Rights. All participants have the following rights with respect to 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 not required to agree your request unless the disclosure is to a health plan for the purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) and the protected health information pertains only to a health care item or service for which the participant has paid the health care provider out-of-pocket and in full. Except as described above, we are not required to agree 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 III.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 six years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same 12-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

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

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

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

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:

Benefit Programs Administration
Attn: Privacy Contact Person
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017-1906
Phone: (562) 463-5000

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 April 2018 and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI. *PHI use and disclosure is regulated by federal law, 45 CFR parts 160 and 164 subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.*

FROM: BOARD OF TRUSTEES
SOUTHERN CALIFORNIA PUBLIC SAFETY RETIREE MEDICAL TRUST
Contact phone number: (562) 463-5000