SUMMARY PLAN DESCRIPTION
OF THE
MEDICAL EXPENSE REIMBURSEMENT PLAN
OF THE
SOUTHERN CALIFORNIA FIREFIGHTERS BENEFIT TRUST

MARCH 2021

Including COBRA General Notice
and
HIPAA Privacy Notice

Based on Medical Expense Reimbursement Plan,
Restated Effective March 1, 2021, including Amendment Nos. 1–10

Dr. 2/2/21

Dear Participants of the Southern California Firefighters Benefit Trust:

The Southern California Firefighters Benefit Trust (the "Trust") was established by firefighters for firefighters. The Trust has grown steadily since establishment and now more than 2,000 firefighters participate in the Trust statewide. The Trust is an employee benefits trust designed to provide financial support during your retirement, in the form of reimbursement of certain retiree medical costs. Your association has negotiated an Employer and/or Employee contribution into this Trust; your Memorandum of Understanding ("MOU") provides specific language regarding contributions to the Trust. By contributing to the Medical Expense Reimbursement Plan of the Southern California Firefighters Benefit Trust, your Association is proactively planning for your retirement by prefunding continually increasing retiree medical expenses.

The Trust is highly tax-favored: Contributions to the Trust are pre-tax dollars; the Trust earnings are not taxable; and when you begin receiving benefit payments in the future, you will not owe taxes on those benefit payments (unlike pension payments, which are taxed).

We are very pleased to distribute to you this Summary Plan Description booklet, which gives general information regarding the operation of the Medical Expense Reimbursement Plan in a question-and-answer (Q&A) format. The booklet also provides a brief summary of the rights and protections to which you are entitled under federal law, a notice of your rights under COBRA, and a HIPAA privacy notice.

The Board of Trustees, which administers the Plan, is made up of fellow firefighters from participating associations. A list of the Trustees with their contact information is included under Q&A 24 of this booklet. The Board of Trustees is totally committed to the successful operation of this Plan, with a goal of helping firefighters and their families lessen the burden of retiree medical costs. We welcome your input and comments.

Best Regards,

Brandon Lucore (Fallbrook Firefighters Association IAFF Local 1622)
Chairman, Board of Trustees
Southern California Firefighters Benefit Trust
March 2021

HIGHLIGHTS OF THE PLAN:

- **Eligibility.** Generally, you will be eligible for monthly benefits as a Regular Beneficiary after separation from employment, if five years of Contributions are made to the Plan on your behalf while working (as negotiated in your MOU) and you have attained age 50. If five years of contributions are not made on your behalf, then you will still be entitled to benefit payments as a Limited Beneficiary up to the balance in your Employee Account (which will be credited with the contributions made on your behalf during employment).

- **Benefits.** The benefits from this Trust come in the form of reimbursement for certain medical costs, which are considered Covered Expenses[1] -- generally reimbursement of healthcare premiums (medical, dental, vision) and tax deductible medical expenses.

- **Claims.** You must submit your claims to the Trust Office along with your proof of payment of Covered Expenses, on a form approved by the Trustees, within 3 months of the end of the calendar year in which you paid the expense, i.e., by March 31st.

- **Change of Address, Spouse, or Child.** 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, and the Trust may charge you a fee if your contact information is not up to date and the Trust has to search for and update contact information on your behalf.

- **Trust Office.** The Trust Office is a great resource and 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. You may contact the Trust Office as follows:

Southern California Firefighter Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017
Phone: 213.406.2370
Toll free: 844.353.7839
scfirefighters@bpabenefits.com
www.firefightertrust.org

NOTE: The questions and answers in this Summary Plan Description ("SPD") have been designed to provide you with key information about the Southern California Firefighters Benefit Trust, but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the Medical Expense Reimbursement Plan of the Southern California Firefighters Benefit Trust, restated effective March 1, 2021, and as amended thereafter ("Plan"). If there is a conflict between what is contained in the Plan and what is contained in the SPD or any other descriptions, the terms of the Plan will prevail. Note that capitalized terms contained herein are defined in the Plan document.

[1] See Q&A 6 for a detailed description of the type of medical expenses for which you will be reimbursed.

TABLE OF QUESTIONS

SUMMARY PLAN DESCRIPTION

1. Who participates in the Trust?

Participation in the Plan is established by a collective bargaining agreement which requires contributions on behalf of all Employees, or a specified class of Employees, who are members of a bargaining unit represented by a Participating Association. The Participating Employer must transfer Contributions to the Trust for all periods of Active Service of the Employee.

2. Who is eligible for benefits from the Trust?

There are two categories of Beneficiaries: Regular Beneficiary and Limited Beneficiary. An Employee can be eligible as both a Limited Beneficiary and a Regular Beneficiary at the same time, or for one or the other, depending on whether the Employee meets the eligibility requirements below.

(a) Eligibility for Regular Beneficiary. An Employee described in Q&A 1 becomes a Regular Beneficiary entitled to benefits under the Plan, generally, after the Employee meets all the following requirements:

- Earns five years of Active Service in the Trust (i.e., through five years of monthly Pooled Contributions to the Trust or through conversion of Lump Sum Transfers equal to five years of Active Service).

- Attains age 50.

- Separates from employment with all Participating Employers. (Return to any employment with a Participating Employer of the Trust 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. A list of Participating Employers is available on the Trust website.)

(b) Eligibility for Limited Beneficiary. An Employee described in Q&A 1 becomes a Limited Beneficiary entitled to benefits from his/her Employee Account in the Plan, generally after the Employee meets all the following requirements:

- There is a balance in the Employee Account from:

    - Lump Sum Transfers (including accumulated leave payouts and San Diego Option C transfers) from the Employer to the Employee Account; or
    - Credit of Pooled Contributions to the Employee Account due to failure to meet the requirements for eligibility as a Regular Beneficiary, or rollover of unused Pooled Account monthly benefits to the Employee Account; and

- Separation from employment with all Participating Employers. (Return to any employment with a Participating Employer of the Trust 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. A list of Participating Employers is available on the Trust website.)

(c) Eligible Retiree with Disability. An Employee, who separates from employment prior to the eligibility age due to a Disability, is eligible as a Regular Beneficiary at age 45, provided the Employee has attained all other eligibility requirements for a Regular Beneficiary. Disability is defined in the Plan as an injury or medical condition incurred in the course and scope of employment as a public safety employee, as determined by an appropriate governmental agency. To be eligible, the Employee must submit documentation to the Trust Office of a determination by a governmental agency that the Employee is unable to work as a public safety employee and the disabling injury or medical condition was incurred during the course and scope of employment as a public safety employee.

(d) Spouse and Surviving Spouse. Any lawful spouse is a Beneficiary of the Eligible Retiree. Please note that the Trust grants the same rights and benefits to same-sex spouses as it does to opposite sex spouses. Please notify the Trust Office of your marriage and provide contact information for your spouse. A Surviving Spouse is the lawful spouse of an Eligible Retiree, who had been the spouse of the Eligible Retiree for at least 12 months on the date of death of the Eligible Retiree. Such a spouse of a deceased Employee, who satisfied all the eligibility requirements except that he/she died before age 50 and/or before separation from employment, is also a Surviving Spouse eligible for benefits. Spouses and Surviving Spouses can be either Regular Beneficiaries or Limited Beneficiaries or both, based upon the eligibility of the Employee.

(e) Child(ren) and Surviving Child(ren). A Child is the natural child, stepchild, foster child, or lawfully adopted child of the Employee or Eligible Retiree, who is under age 26. Children over age 26, who are legally dependent on the Eligible Retiree due to a Social Security Administration determination of total disability, are eligible as Children for so long as the child remains totally disabled. A Surviving Child is the Child of the Eligible Retiree who met the eligibility requirements on the date of the Eligible Retiree's death and continues to meet those eligibility requirements. The Child of an Employee, who satisfied all the eligibility requirements except that he/she died before age 50 and/or before separation from employment, is also a Surviving Child eligible for benefits. Children and Surviving Children can be either Regular Beneficiaries or Limited Beneficiaries or both, based upon the eligibility of the Employee.

3. What are Pooled Contributions and what is the Pooled Account?

Pooled Contributions are monthly transfers of money from the Employer to the Trust, pursuant to a MOU, on behalf of all active employees participating in the Trust. These Contributions may be employer and/or employee contributions, as negotiated in the MOU. The Pooled Account is the investment account within the Trust that holds these Pooled Contributions. Monthly benefits for Regular Beneficiaries are paid from the Pooled Account. See Q&A 7 for a description of the formula for calculating Pooled Account monthly benefits for Regular Beneficiaries. A professional investment manager manages the investment of the Pooled Account, and the Pooled Account balance includes tax-free investment earnings.

4. What happens if I separate from service before I contribute to the Trust for five years?

If an Employee does not earn the five years of Active Service necessary to become a Regular Beneficiary, that Employee is classified as a Limited Beneficiary. Instead of receiving a lifetime[2] stream of monthly reimbursement benefit payments, the Trust will credit to an Employee Account the amount of Pooled Contributions made to the Trust on behalf of that Employee over his/her career (without any allotment for prior investment gains and/or losses). That is, the Trust Office will credit the amount of Pooled Contributions of a Limited Beneficiary to a recordkeeping Employee Account, along with any Lump Sum Transfers received on his/her behalf. The Trust Office will allocate investment earnings and losses and administrative expenses to the Employee Account after the Account is established. The Limited Beneficiary may draw on that Account for the reimbursement of Covered Expenses, after separation from employment with all Participating Employers. There is no monthly limit on the benefits for a Limited Beneficiary, but all claims must be for reimbursement of Covered Expenses. Limited Beneficiary benefits cease when the Employee Account balance reaches zero.

5. What are the benefits from the Trust?

After meeting the eligibility requirements, both Regular Beneficiaries and Limited Beneficiaries are entitled to reimbursement toward the payment of Covered Expenses, which consist of insurance premiums and medical expenses paid by the Employee after becoming eligible for benefits under the Plan. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment is limited to the Beneficiary's monthly Benefit Level (for a Regular Beneficiary), or the balance in his/her Employee Account (for a Limited Beneficiary).

Cost Sharing. It is important to remember that the Plan reimburses toward the cost of Covered Expenses, but your Benefit Level or Employee Account may not cover the entire

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

Covered Expense amount. If your benefit from the Plan does not cover the entire cost of your Covered Expense, you will be responsible for the balance of any Covered Expense amounts you owe in excess of your benefit.

6. What type of medical expenses does the Plan reimburse?

The following medical expenses are considered Covered Expenses and will be reimbursed by the Plan up to your monthly Benefit Level or Employee Account balance:

- Premium or contribution payments for coverage under health, dental, or vision insurance plans, 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 expenses excludable from gross income under Code Section 213(d) (i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury including insulin, but excluding all other nonprescribed drugs).

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

You can also reference IRS Publication 502 for a detailed description of tax deductible medical expenses at http://www.irs.gov/pub/irs-pdf/p502.pdf.

7. How is the monthly Benefit Level from the Pooled Account calculated for Regular Beneficiaries?

A Regular Beneficiary's monthly Pooled Account Benefit Level is determined by the number of Active Service Units he/she has accrued in this Plan, and the Unit Multiplier in effect when the Beneficiary's claim is received by the Trust Office. The steps for the calculation are as follows:

- Determine your total number of Active Service Units
- Multiply the total number of Active Service Units by the Unit Multiplier

From time to time, the Trustees will determine the Unit Multiplier, with the assistance of professional actuarial advice. At publication of this SPD, the Unit Multiplier was 0.23. You may contact the Trust Office to find out the current Unit Multiplier.

Adjustments to Benefit Level. The Trustees reserve the right and power to adjust the Unit Multiplier or the benefit levels up or down. Such adjustments, or termination of benefits, may apply to some or all current or future Beneficiaries. This could occur, generally, after the Trustees conduct a periodic review of the investment and demographic experience of the Trust. That is, if the investment returns or the demographic experience (e.g., life span, retirement age, etc.) are significantly different than projected, then the Trustees could adjust the Unit Multiplier or benefit levels (up or down).

8. How do I earn Active Service? What is the difference between Active Service and Active Service Units (ASUs)?

An Employee may earn Active Service in the following ways:

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

- Conversion of Employee Account. See Q&A 10 and 13.

- Contribution After Termination or Reduction of Employment. 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-pay contributions to the Trust as permitted by the federal law known as COBRA,[3] 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. See Q&A 2.

- Active Service Units reflect the number of $25 contributions made on your behalf to the Trust, i.e., a $25 contribution earns one Active Service Unit. The number of Active Service Units is a factor in determining your monthly Benefit Level.

9. Why is my own monthly Benefit Level from the Pooled Account different from other retirees?

A Regular Beneficiary's monthly Pooled Account Benefit Level is calculated by the methodology described in Q&A 7. Accordingly, each Regular Beneficiary's monthly Benefit Level will be affected by the number of Active Service Units earned by that retiree over his or her career. An Employee earns one Active Service Unit for each $25 monthly Pooled Contribution made to the Trust on his/her behalf.

The Employee's bargaining unit negotiates the monthly Pooled Contribution rate. For example, a monthly Pooled Contribution rate of $150 will provide six Active Service Units per month to each Employee in that bargaining unit, and a monthly Pooled Contribution rate of $200 will provide eight Active Service Units per month. Thus, Regular Beneficiaries from different bargaining groups will have different monthly Pooled Account benefit levels, depending on what Pooled Contribution rate their bargaining group selected and negotiated. The period of time during which Pooled Contributions were made on your

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

behalf and the Pooled Contribution rate of your bargaining group during your participation will also affect your total ASUs, which may make your monthly Benefit Level different from another Regular Beneficiary in your own bargaining group.

10. Can a Beneficiary use funds in his/her Employee Account to purchase additional Active Service Units in order to increase his/her monthly benefit level?

Yes, an Employee can transfer lump sum amounts of $3,000 or more from his/her Employee Account into the Pooled Account to earn Active Service Units in the Plan. The Employee must request these transfers in writing to the Trust Office (on a Conversion Election Form supplied by the Trust Office) and may make only one transfer request per calendar year. The lump sum amount transferred from the Employee Account to the Pooled Account is converted to Active Service Units at separation from employment on an actuarially equivalent basis, using the "Active Service Unit Conversion Table," attached to the Plan as Appendix B. When you review the Conversion Table in Appendix B, you will note that the conversion rate may be more or less than the regular monthly Pooled Contribution rate of $25 per Active Service Unit. The rates in Appendix B were actuarially calculated to be equivalent to monthly Pooled Contributions during employment. The rates are higher or lower based on the time that the funds will be invested in the Pooled Account prior to retirement. Examples of conversions of lump sum transfers to Active Service Units are also available for your reference in Appendix C to the Plan. These examples illustrate the cost of conversion of Employee Account funds to Active Service Units in different circumstances. If you need a copy of Appendix B or C, please contact the Trust Office. Please note that Appendix B is periodically updated by the Trust actuary, and the Appendix B that applies to your conversion is based upon the date that your Conversion Election Form is received at the Trust Office.

You can elect multiple conversions during your active employment, but no more than one time per calendar year. <u>If you are retired or separated from service, you have 60 days from the date of mailing of the conversion packet to deliver your Conversion Election Form to the Trust Office. Conversion packets are mailed when the Trust receives a new lump sum contribution to the Employee Account, which will often happen at retirement</u>.[4] For more information on conversion of Employee Account funds to Active Service Units, request a copy of the Bulletin Re Conversion of Employee Account Funds to Active Service Units from the Trust Office.

11. What Benefit Level will my spouse and Children receive in the event of my death?

<u>Monthly Pooled Account Benefit Level – Regular Beneficiary</u>. If there are Surviving Children, then the monthly Pooled Account Benefit Level for the Surviving Spouse is equal to 75% of the Benefit Level of the deceased Eligible Retiree. If there are no Surviving Children, then the monthly Pooled Account Benefit Level for the Surviving Spouse is equal to 50% of the Benefit Level of the deceased Eligible Retiree. If there is no Surviving

[4] Accrued leave transfers to the Trust are bargained in your MOU and must be the same for all members of the bargaining unit.

Spouse, the monthly Pooled Account Benefit Level for Surviving Children is equal to 75% of the Benefit Level of the deceased Eligible Retiree (to be divided among the Surviving Children).

Employee Account Benefits – Limited Beneficiaries. If the Employee had an Employee Account with a positive balance upon his or her death, then the Surviving Spouse may be reimbursed for Covered Expenses from that Account, until the balance in the decedent's Employee Account is exhausted. Benefits to the Surviving Spouse cease when the Employee Account balance reaches zero or upon the Surviving Spouse's death. If there is no Surviving Spouse, then the Surviving Children may be reimbursed for Covered Expenses from the Employee Account until the account balance reaches zero, the Child loses Child status under the Plan, or the Child dies, whichever occurs first.

12. Why would a Regular Beneficiary have an Employee Account?

A Regular Beneficiary may have an Employee Account to hold Lump Sum Transfers, such as mandatory transfers of sick and/or vacation leave payout, or other negotiated lump sum contributions as allowed under the Plan (for example, San Diego City "Option C" transfers). Also, if a Regular Beneficiary has not used his/her entire Pooled Account monthly benefits by the following February 28th (end of the plan year), then the unused Pooled Account monthly benefits are transferred to an Employee Account. A Regular Beneficiary can receive reimbursement of Covered Expenses from his/her Employee Account as a Limited Beneficiary at the same time that he/she receives a Pooled Account monthly benefit. If a participant is both a Regular Beneficiary and a Limited Beneficiary, the Trust Office will pay claims from the Pooled Account monthly benefit first and then reimburse the remainder of the claim from the Employee Account balance, unless the Beneficiary instructs otherwise.

13. Can a Limited Beneficiary use Employee Account funds to attain eligibility for the Pooled Account monthly benefit?

Yes, an Employee who has not earned the five years of Active Service prior to separation from service has the option to convert his/her Employee Account balance to Active Service Units. See Q&A 10. The Employee can convert the minimum amount of the Employee Account needed to reach the minimum five years of Active Service for eligibility as a Regular Beneficiary, or the Employee can convert more than the minimum amount and increase his or her Pooled Account monthly Benefit Level above the minimum.[5] For purposes of meeting the Active Service threshold for eligibility as a Regular Beneficiary, the Active Service Units required for one year of Active Service are equal to the annual number of Active Service Units earned per active Employee in the Employee's Association through Pooled Contributions.

[5] In this situation, you may also be eligible to make after-tax COBRA payments to attain the Active Service eligibility requirement. See the COBRA General Notice for more information.

14. Can I select the investment for my Employee Account?

Yes, the Trustees have implemented investment Portfolio options for the investment of Employee Accounts. The rules for investment selection and the descriptions of the investment Portfolio options are included in the "Informational Bulletin for the Portfolio Selection Form," which is distributed to you annually in a packet of documents for the annual investment selection period. You should have received this Bulletin when your Employee Account was first established and annually during the investment selection period generally in April. If you did not receive the Bulletin or need another copy, please contact the Trust Office. The Trustees reserve the right to change or terminate the investment options for Employee Accounts at any time.

15. How do I submit my claims for benefits?

To present a claim for benefits under this Plan, the Employee or Surviving Spouse or Child must submit a written claim, on a form approved by the Trustees. Claims must be submitted to the Trust Office (see contact information below) within 3 months of the end of the calendar year in which he/she paid the expense (i.e., by March 31st for any expenses paid during the prior calendar year). While the Trust Office may waive the deadline for good cause shown, please do not assume that any circumstance will constitute good cause.

Southern California Firefighter Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017
Phone: 213.406.2370
Toll free: 844.353.7839
scfirefighters@bpabenefits.com
www.firefightertrust.org

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, which can include one of the following or other proof approved by the Board of Trustees:
    - 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 a pension statement showing a deduction for premium payments.

- Receipt for payment from the medical service, supplies, or insurance provider.

Reimbursement of Insurance Premiums. 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.

Recoupment of Overpayments. In the event the Trust overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments or your Employee Account balance, to the extent allowed by federal law. Alternatively, the Trust may seek repayment of the overpaid amount from you directly to the Trust.

Authority/Priority to Submit Claims. 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. The Eligible Retiree can submit claims for Covered Expenses of his or her legal spouse[6] and Children, but there is only one monthly benefit level for reimbursement of all Beneficiaries' claims. After the death of the Eligible Retiree, the Surviving Spouse has the right to submit claims. If 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 the claims to the Trust Office and sign the claims form on the Beneficiary's 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.

[6] 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. Please keep the Trust Office notified of your marital status and your current spouse. 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.

16. What happens if a Regular Beneficiary has high monthly claims in one month? Can the excess Covered Expenses carry over for reimbursement in a later month?

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

17. What happens if a Regular Beneficiary doesn't use his/her full monthly Benefit Level each month?

If you do not use your entire Pooled Account monthly Benefit Level for one month, then the unused amount of your monthly Benefit Level will carry over to the next month. If you do not use the accumulated unused benefits by the end of the Plan year on February 28th, then the accumulated unused benefits are credited to your Employee Account. The rollover of accumulated unused benefits to an Employee Account also includes unused benefits from a period that you were employed by a Participating Employer. See Q&A 23. Rollover of unused benefits generally occurs by July 1 each year.

18. How do I appeal a denied claim or other adverse determination of the Trust Office?

Any individual whose claim is denied or who receives an adverse determination related to the Plan may appeal to the Board of Trustees to conduct a hearing in the matter. Note that the appeal procedures apply to any complaint that you may have regarding the Plan (i.e., not just a claim denial). 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 other 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 for the hearing. The Board of Trustees will then issue a written decision affirming, modifying, or setting aside the Trust Office decision. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

The Trustees have broad discretionary authority to determine eligibility for benefits, to grant or deny claims for benefits, to interpret and apply the provisions of this Plan, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision is binding and conclusive.

19. 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 18), 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.

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

No, the Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Covered Expenses you will submit to the Plan for payment. The Plan will not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. (There is an exception for incompetent Beneficiaries with a court appointed representative and for a family member who pays for a Beneficiary's Covered Expenses.)

21. What is the Plan year?

The Plan year runs from March 1 to February 28.

22. What should I do if I change my address, spouse, or add 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. Please update the Trust Office with any changes to your address or Beneficiaries by contacting the following:

Southern California Firefighter Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017
Phone: 213.406.2370
Toll Free: 844.353.7839
scfirefighters@bpabenefits.com
www.firefightertrust.org

The Trustees may charge a reasonable fee by deduction from your monthly benefits or Employee Account in order to recoup the costs to the Trust of finding your missing contact information.

23. 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 documentation of 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* monthly Pooled Account benefits under this Plan will terminate upon his/her death. Employee Account benefits under this Plan will terminate when the Employee Account balance reaches zero or upon the Eligible Retiree's death.

- An *Eligible Retiree's* Pooled Account monthly benefits and Employee Account benefits will be suspended upon return to employment with any Participating Employer of the Trust. However, benefit payments will resume after the Eligible Retiree ceases all employment with Participating Employers. Monthly benefits that are unused during a period of re-employment are rolled over to an Employee Account after the end of the plan year (generally on or before July 1st each year) for use later after the Eligible Retiree ceases all employment with Participating Employers.

- A *Surviving Spouse's* monthly Pooled Account benefits under this Plan will terminate upon his/her death. Employee Account benefits under this Plan will terminate when the Employee Account balance reaches zero or upon the Surviving Spouse's death.

- A *Surviving Child's* benefits from the Pooled Account will terminate upon death of the Child or the loss of Child status under this Plan (i.e., on the Child's 26th birthday). Employee Account benefits under this Plan will terminate when the Employee Account balance reaches zero, upon loss of Child status, or upon the Child's death.

The Trustees may modify or terminate benefit coverage and benefit levels 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 the termination of the Plan, the Trustees will allocate and distribute assets of the Plan remaining after payment of expenses associated with termination in accordance with Code Section 501(c)(9).

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

You can reach the Trustees via mail, or serve process on the Trustees through the following Trust Office address:

Southern California Firefighter Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017

The Trustees are as follows:

Brandon Lucore, Fallbrook
Ryan Garing, Fallbrook
Greg Wilson, Fallbrook
Matt Mathis, Riverside
Michael DeToy, Riverside
Dirk Jensen, Riverside Retiree
Ron Saathoff, San Diego
Abe Hunt, San Diego
Steve Vandewalle, San Diego

25. 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 Firefighters Benefit Trust, restated effective March 1, 2021, and as amended from time to time thereafter (the "Plan," *Dr. 2/11/21 incl. Amendment Nos. 1–10*). The Plan is governed by the Trust Agreement Governing the Southern California Firefighters Benefit Trust, effective November 1, 2008, and as amended from time to time thereafter ("Trust Agreement," 11/09/09 Ed.). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

B. The name, address, and telephone number of the employee organizations that established this Plan.

The Southern California Firefighters Benefit Trust was established by the Fallbrook Firefighters Association Local 1622 ("FFA") and the Riverside City Firefighters Local 1067 ("RCFA"). (San Diego County Regional Public Safety Trust, formed by the FFA, and the Inland Empire Firefighters Trust, formed by the RCFA, merged in 2008, resulting in the newly created "Southern California Firefighters Benefit Trust"). The address and telephone numbers of the Associations are as follows:

Fallbrook Firefighters Association Local 1622
P. O. Box 553
Fallbrook, CA 92088

Riverside City Firefighters Local 1067
P. O. Box 7817
Riverside, CA 92513

C. **The identification numbers of the Trust and the Plan.**

The Employer Tax Identification Number (EIN) assigned to the Trust by the Internal Revenue Service is 43-6921041. The Plan number is 501.

D. **The type of plan.**

The Plan is a welfare benefit plan providing health insurance premiums 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 Firefighter Benefit 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 Firefighter Benefit Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017
Phone: 213.406.2370
Toll free: 844.353.7839
scfirefighters@bpabenefits.com
www.firefightertrust.org

F. **The identity of the Plan Administrator.**

The Plan Administrator (fiduciary) is the Board of Trustees of the Southern California Firefighter Benefit Trust. They may be contacted through the Trust Office.

G. **The existence of bargaining agreements that address this Plan and Trust.**

The Plan is maintained pursuant to a MOU between the Employer and each of the participating Associations. Beneficiaries of the Plan, 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 learn more about the right to self-pay contributions during FMLA leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

I. **Uniformed Services Employment and Reemployment Rights Act (USERRA).**

If 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. **Information regarding COBRA.**

The COBRA General Notice is provided in this booklet and also as a separate notice from this Summary Plan Description. If you have not received or would like to request a copy of the COBRA General Notice, please contact the Trust Office. The COBRA General Notice is also posted on the Trust website at www.firefightertrust.org.

K. **The procedures governing Qualified Domestic Relation Order (QDRO) and Qualified Medical Child Support Order (QMCSO) determinations.**

The parties to a divorce proceeding can divide the monthly benefits and Employee Account 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 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 of the Participant. (You may also submit your own proposed QDRO, but it will be subject to review and approval by the Trust.) Beneficiaries can also obtain review of a QMCSO from the Trust Office.

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 or Employee Account balance. The costs may vary from one divorce situation to another and may be spread amongst several months of benefit payments.

L. **The source of contributions to the Trust.**

Contributions to this Plan must be nonelective and are made by the participating Employers and/or Employees, based on the MOUs with the participating Association(s). Further, under certain circumstances, Beneficiaries may make self-pay contributions pursuant to federal COBRA law.

M. **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 the Employee Retirement Income Security Act of 1974 (ERISA) requirements.

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. See address in Q&A 24. Service of legal process may be made upon a Trustee or the Trust Office, c/o Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, CA 90017.

O. **Statement of Legal Rights.**

- Rights of Plan Participants. Beneficiaries of the Southern California Firefighters Benefit Trust are entitled to certain rights and protections 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 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 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 the summary annual report.

If there is a cessation of Pooled Contributions to the Plan as a result of a COBRA qualifying event, you or your family members may have to self-pay contributions. Review the COBRA General Notice 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 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 Trust Office. If you have any questions about this statement or about your rights under ERISA or if you need assistance in

obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866.444.EBSA (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.

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

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of your health care costs after termination, resignation or retirement and attainment of the eligibility age (currently 50),[7] 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 "Medical Expense Reimbursement Plan" (hereafter the "Plan") of the Southern California Firefighters Benefit Trust (hereafter the "Trust"), which provides reimbursement towards certain 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."[8]

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAY CONTRIBUTIONS UNDER 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 for Benefits After Retirement.**

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to self-pay contributions to the Trust, when contributions to the Trust would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying

[7] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not provide current healthcare insurance coverage. This plan reimburses the cost of premiums or medical expenses, but not until separation or retirement and attainment of eligibility.
[8] Public Law 99-272, Title X.

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 as follows:

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

ii) To augment their monthly post-retirement benefit, if the person had already met the 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 medical expense reimbursement benefits, this Plan requires that the Employee earn five 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.

Further, since the Plan also provides for a gradually increasing level of benefits based on the number of years of contributions, you may be able to increase your monthly benefit level if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to make self-pay contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 6** below.

C. Consequence of Non-Election. If you do not choose to continue contributing to this Plan and have not earned five years of Active Service, you will be eligible to receive benefits limited to the balance credited to your Employee Account.

D. Widowed spouses and children. Widowed spouses and children may also have the right to 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. 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

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

ii) Reduction of Work Hours. Your hours of employment are reduced, including a cessation of contributions on your behalf due to leave of absence.

Either of these Qualifying Events generally gives you the right to self-pay 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,"[10] and provided that the Employee does not elect to self-pay contributions under COBRA*:

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

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

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

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-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 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 the Employee parent's employment (for reasons other than gross misconduct);

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

[10] 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.

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

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

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;

iii) 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);

iv) A Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time prior to or during the first 60 days of self-pay contributions; or

v) A Qualified Beneficiary, who was determined as disabled is subsequently determined by the Social Security Administration as no longer disabled.

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

i) Qualifying Events Other Than Disability. The period of time for providing notice to the Trust Office for 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** below).

ii) Qualifying Event of Disability. The period of time 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 eighteen (18) months 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 of time 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 Firefighters Benefit Trust
c/o Benefit Programs Administration
Attn: Ms. Selene Calderon
1200 Wilshire Blvd
Los Angeles, CA 90017
844.353.7839
scfirefighters@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 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-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 self-pay contributions to the Trust for 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-pay 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 self-pay contribution rights, you should contact the Trust Office at the address and/or phone number appearing below.

Southern California Firefighters Benefit Trust
c/o Benefit Programs Administration
Attn: Ms. Selene Calderon
1200 Wilshire Blvd
Los Angeles, CA 90017
844.353.7839
scfirefighters@bpabenefits.com

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

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

NOTICE OF PRIVACY PRACTICES

WITH RESPECT TO PROTECTED HEALTH INFORMATION

Introduction: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to 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 Firefighters Benefit 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. The Trust is 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 always 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. 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 to 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 Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
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 FIREFIGHTERS BENEFIT TRUST
Contact phone number: 562.463.5000