MEDICAL EXPENSE REIMBURSEMENT PLAN

OF THE

HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO RETIREE MEDICAL TRUST

Effective March 1, 2023

(01/23/23 Dr. Incl. Amendment Nos. 1-15)

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TABLE OF CONTENTS
Page

SECTION 1. DEFINITIONS 1
1.1 "Active Service". 1
1.1(b) "Active Service Unit" or "ASU" 1
1.2 "Beneficiary" 2
1.3 "Board of Trustees" or "Trustees" 2
1.4 "Child(ren)" 2
1.5 "Code" 2
1.6 "Collective Bargaining Agreement" or "CBA" 2
1.7 "Contribution" 2
1.8 "Covered Expense" 3
1.9 "Effective Date" 3
1.10 "Employee" 3
1.11 "Employee Account" 3
1.12 "Employer" or "Participating Employer" ....
1.13 "Local" 4
1.14 "Missing Participant" 4
1.15 "Modify". 4
1.16 "Operative Period" 4
1.17 "Plan" 4
1.18 "QDRO" or "qualified domestic order" 4
1.19 "QMCSO" or "qualified medical child support order" 4
1.20 "Subscription Agreement" 4
1.21 "Surviving Spouse" or "Surviving Domestic Partner" 4
1.22 "Trust" or "Trust Fund" 4
1.23 "Trust Agreement" or "Agreement" ....
1.24 "Unit Multiplier" or "UM" 5

SECTION 2. ENTITLEMENT TO BENEFITS 5
2.1 Eligibility 5
2.2 Active Service 7
2.3 Self-Pay Contributions. 8
2.4 No Rebate or Refund. 8

SECTION 3. BENEFITS 8
3.1 General 8
3.2 Commencement of Benefits. 9
3.3 Benefit Levels for Regular Beneficiaries. 9
3.4 Termination of Benefits. 12
3.5 Benefits from Employee Accounts 13
3.6 Benefit Claim Procedure 14
3.7 Prohibition of Assignment and Protection from Creditors 16

SECTION 4. CLAIM APPEAL PROCEDURES 17
4.1 Beneficiary's Duty to Notify Trust Office of Claim. 17
4.2 Acceptance or Denial of Claims by the Trust Office. 17
4.3 Appeal Procedures. 18
4.4 Right to Court Review, Time Limit to Bring Lawsuit 20

SECTION 5. MISCELLANEOUS 20
5.1 Limitation of Rights.. 20
5.2 Applicable Laws and Regulations. 20
5.3 Confidentiality. 20
5.4 Trustee Authority. 20
5.5 Divorce and Court Orders: QDRO and QMCSO Review Costs. 20
5.6 Missing Participant Polices and Procedures. 21
5.7 Right of Subrogation…....................21

SECTION 6. AMENDMENTS AND TERMINATION 25
6.1 25

SECTION 7. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION 255
7.1 General. 255
7.2 Disclosure to the Board of Trustees 26
7.3 Security of Electronic PHI. 27

APPENDIX A 28
APPENDIX B 29
APPENDIX C 31

PREAMBLE

WHEREAS the Health Professionals and Allied Employees, AFT/AFL-CIO (hereafter "HPAE"), is a labor organization under the National Labor Relations Act, whose Local Unions negotiate benefits on behalf of their members; and

WHEREAS, the HPAE Locals have entered into, or intend to enter into, collective bargaining agreements regarding retiree medical expense benefits for their members, wherein the bargaining parties will agree that mandatory contributions would be made to an employee benefit trust on behalf of each and every Employee in the bargaining unit for the purpose of funding, in whole or in part, retiree health benefits; and

WHEREAS, the HPAE established such a trust as of January 1, 2007, granting administration of the Trust to a Board of Trustees pursuant to the "Trust Agreement Governing the Health Professionals and Allied Employees Retiree Medical Trust," effective July 1, 2006; and

WHEREAS, the Board of Trustees of the aforementioned Trust adopted the Medical Expense Reimbursement Program of the Health Professionals and Allied Employees, AFT/AFL-CIO, Retiree Medical Trust, effective January 1, 2007, which was has been restated several times, most recently effective July 1, 2019, to include Plan Amendment Nos. 1-15; and the Plan restated effective August 1, 2014, changed the name of the Plan to the Medical Expense Reimbursement Plan from the Medical Expense Reimbursement Program; and now wishes to integrate the Amendments into the Plan document, to make necessary legal updates, and to correct minor scrivener's errors.

NOW, THEREFORE, the Board of Trustees does hereby adopt this restated Medical Expense Reimbursement Plan of the Health Professionals and Allied Employees, AFT/AFL-CIO, Retiree Medical Trust, effective March 1, 2023, including Amendment Nos. 1-15.

SECTION 1. DEFINITIONS

Where the following words and phrases appear in this Plan, they shall have the meaning set forth in this Article, unless the context clearly indicates otherwise. Other words and phrases with special meanings are defined where they first appear unless their meanings are apparent from the context.

1.1 **"Active Service"** means service as defined in Section 2.2 hereof, after the Employee's Effective Date. Effective for an Employee with one Contribution to the Trust on or after August 1, 2014, the Trust will grant one year of Active Service for any calendar year in which the

employee has 850 contributory hours in the Trust. Active Service is a factor used to determine eligibility as a Regular Beneficiary under Section 2.1(a) hereof.

1.1(b) An "Active Service Unit" or **"ASU"** is earned each time the Contributions on behalf of an Employee amount to $5.00. The Trust will grant 1/100 ASU for each Contribution of $0.05 and when the Trust Office has received Contributions totaling $5.00, it will grant one ASU. The number of ASUs an Employee earns is a factor in determining his/her Benefit Level as a Regular Beneficiary under Subsection 3.3(a) hereof.

1.2 "Beneficiary" means any person eligible to receive benefits as a Regular Beneficiary or Limited Beneficiary, his or her lawful spouse and Children, and the Surviving Spouse, and Surviving Children of a Regular Beneficiary or Limited Beneficiary. A "**Regular Beneficiary**" is a person who has become eligible for monthly benefits under Subsection 2.1(a); provided that an Employee who has satisfied all the requirements of Subsection 2.1(a), except the Employee dies prior to reaching the eligibility age set forth in Subsection 2.1(a)(3), shall also be considered a Regular Beneficiary. A "**Limited Beneficiary**" is a person who has become eligible for benefits from an Employee Account under Subsection 2.1(b).

1.3 "Board of Trustees" or "Trustees" means the duly selected Board, which administers the Plan and Trust, pursuant to the Trust Agreement.

1.4 "Child(ren)" means a natural child or lawfully adopted child of the Employee, Regular Beneficiary or Limited Beneficiary, or child placed in the home of the Employee, Regular Beneficiary or Limited Beneficiary for adoption by the Employee, Regular Beneficiary or Limited Beneficiary, who either: (a) is under the age of 26; or (b) is legally dependent upon the Regular Beneficiary, Limited Beneficiary or Employee for support and maintenance, for so long as the child is determined to be totally disabled by the Social Security Administration. **"Surviving Child(ren)"** means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Beneficiary's death and who continues to meet that definition.

1.5 "Code" means the Internal Revenue Code, as amended.

1.6 "Collective Bargaining Agreement" or "CBA" means a written agreement between an Employer and a Local that requires mandatory Contributions to the Trust on behalf of every Employee in the bargaining unit for retiree medical benefits, and subsequent amendments or successor agreements. A CBA also includes a "Subscription Agreement" as defined herein.

1.7 "Contribution" means a mandatory transfer to the Trust made by or on behalf of all Employees in a specific classification within a bargaining unit represented by a Local, pursuant to a Collective Bargaining Agreement between a Participating Employer and a Local.

(a) Except for sick and/or vacation leave transfers, contributions shall be made at the level of at least $0.10/hour worked, or such higher amount as is divisible by $0.05.

(b) Contributions made prior to August 1, 2014, shall be converted, according to rules set by the Trustees, into Active Service Units, for purposes of determining a Regular Beneficiary's monthly Benefit Level under Subsection 3.3(a) hereof.

(c) All Contributions must be made without any election on the part of an individual employee (except for contributions made pursuant to continuation requirements of federal law under IRC Sec. 4980B). Any elective contributions (other than under 4980B) will be returned within thirty (30) days of discovery that the contribution was made by individual election, as allowed by law and approved by the Board of Trustees, and Active Service Units granted based on an elective contribution will be rescinded.

1.8 **"Covered Expense"** means payment by a Beneficiary for any of the following:

(a) Premium or contribution on behalf of a Beneficiary to a health, dental, or vision insurance plan, for coverage of the Beneficiary in effect while the Beneficiary is eligible for benefits under this Plan, for the type of medical expenses excludible from gross income under Code Section 105(b);

(b) Medical expenses, as defined in Code Section 213(d), (i.e., costs for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury), including insulin but excluding all other non-prescribed drugs, for medical services and supplies paid for while the Beneficiary is eligible for benefits under this Plan and which has not been claimed by the Beneficiary as a deduction on his or her personal tax return; and

(c) Premium payment for long-term care insurance, qualified as tax deductible under Code Section 7702B, for coverage of a Beneficiary in effect while the Beneficiary is eligible for benefits under the Plan, but for no other expenses associated with the costs of long-term care unless such expenses qualify for reimbursement under Subsection 1.8(b) above.

1.9 **"Effective Date"** for an Employee means the date that Contributions for that Employee's Local are required and made to the Trust on behalf of the Employee, as approved by the Trustees.

1.10 **"Employee"** means an individual while employed by a Participating Employer; who is a member of a bargaining unit represented by a Local; and on whom the required Contributions are made to the Trust pursuant to a Collective Bargaining Agreement for all periods of Active Service after the Effective Date, and such individuals who later retire or separate from employment with the Participating Employer.

1.11 **"Employee Account"** means the individual bookkeeping account maintained by the Trust in the name of an Employee or Beneficiary, which reflects certain Contributions made to the Trust as set forth in Section 3.5.

1.12 “Employer” or **“Participating Employer”** means an employer (as further defined in the Trust Agreement), which contributes to this Plan pursuant to a CBA.

1.13 “Local” means a participating labor organization or bargaining unit, which has signed a Collective Bargaining Agreement with a Participating Employer and for which the Trustees have approved participation in the Trust; or any group that is the subject of a Subscription Agreement with the Trustees.

1.14 “Missing Participant” means an Employee, Surviving Spouse, or known Surviving Child for whom the Trust Office has no address information on file in Trust records, or for whom Trust mail communications have been returned to sender without a valid forwarding address.

1.15 “Modify” means to adjust, including increase or decrease.

1.16 “Operative Period” means the period during which the corresponding Unit Multiplier is effective; the Unit Multiplier used to calculate the Benefit Level for a Regular Beneficiary is effective for claims paid by the Trust Office during the Operative Period of the Unit Multiplier. See Appendix A to the Plan.

1.17 “Plan” means the entire benefit plan codified in this separate written document, together with any amendments duly adopted by the Trustees.

1.18 “QDRO” means a qualified domestic relations order as defined in ERISA Section 206(d)(3)(B), 29 USC 1056(d)(3)(B).

1.19 “QMCSO” means a qualified medical child support order as defined in ERISA Section 609(a)(2)(A), 29 USC 1169(a)(2)(A).

1.20 “Subscription Agreement” means a written agreement between an entity and the Trustees and any supplement, amendment, continuation, or renewal thereof that obligates the entity to make Contributions to the Trust Fund for Employees, for the purpose of providing employee welfare benefits to the Employees covered by said agreement and their Beneficiaries.

1.21 “Surviving Spouse” means the lawful spouse, as defined in the Internal Revenue Code, of a Regular Beneficiary or Limited Beneficiary, who was in that status at least 12 months on the date of the death of the Regular Beneficiary or Limited Beneficiary.

1.22 “Trust” or **“Trust Fund”** means the Health Professionals and Allied Employees Retiree Medical Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records. **“Trust Office”** means the third party administrator selected by the Trustees.

1.23 “Trust Agreement” or “**Agreement”** means the Trust Agreement governing the Health Professionals and Allied Employees AFT/AFL-CIO Retiree Medical Trust, effective July 1, 2006, and any amendments thereof.

1.24 "Unit Multiplier" or **"UM"** means the variable amount periodically set by the Trustees, based on demographic and financial factors, and used in the determination of the monthly Benefit Level of a Regular Beneficiary, as set forth in Subsection 3.3(a). The Trustees may adjust the UM up or down from time to time.

SECTION 2. ENTITLEMENT TO BENEFITS

2.1 Eligibility

(a) Eligibility as a Regular Beneficiary. An Employee, and his or her Beneficiaries, shall become entitled to monthly benefits under Section 3.3 hereof, as Regular Beneficiaries, when the Employee meets the following requirements:

(1) Earns five (5) years of Active Service after the Employee's Effective Date;

(2) Has terminated from all employment with his or her Participating Employer; and

(3) Attains age 55.

An individual, who is eligible as a Regular Beneficiary, can also be eligible as a Limited Beneficiary, particularly due to transfer of leave to the Employee Account.

(b) Eligibility as a Limited Beneficiary. An Employee, and his or her Beneficiaries, shall become entitled to Employee Account benefits under Section 3.5 hereof, as Limited Beneficiaries, when the Employee meets the following requirements:

(1) The Employee has a positive Employee Account balance, pursuant to Section 2.1(c) hereof;

(2) The Employee has terminated all employment with all Participating Employers.

(3) The Employee has attained one of the following age eligibility requirements:

a. The Employee is between the ages of 40 and 55, and the Plan has not received Contributions on his/her behalf for 24 consecutive months; or

b. The Employee has attained age 55; or

c. The Employee has not attained age 55, but has received a Social Security determination of disability.

(c) Limited Beneficiaries: Employee Account Balance. A Limited Beneficiary shall have an Employee Account with a balance consisting of the following items credited or debited to his or her Employee Account, according to the following rules:

(1) *Employee Contributions*. The Trust Office shall calculate Employee Contributions to the Plan on behalf of an Employee who earns less than five years of Active Service and credit them to an Employee Account, according to rules set by the Board of Trustees.

(2) *Employer Contributions*. Generally, Employer Contributions will not be credited to the account of an Employee who earns less than five years of Active Service in the Plan. However, the Trust Office shall also credit Employer Contributions made to the Plan on behalf of such an Employee to his or her Employee Account, according to rules set by the Board of Trustees, if:

a. The Employee was 50 years old or older on his or her Effective Date in this Plan but did not earn five years of Active Service before terminating employment with a Participating employer; or

b. The Employee was unable to complete five years of Active Service with the Participating Employer because of a disability, and the Employee received a Social Security determination of disability; or

c. The Employee qualifies as a Regular Beneficiary under Subsection 2.1(a) and elects an Employee Account benefit pursuant to Subsection 3.3(b) hereof.

(3) *Sick/Vacation Leave Transfers*. The amount of sick and/or vacation leave transfers will be credited to the Employee Account unless the CBA provides that it will be converted into Active Service Units, which will be done according to Subsection 2.2(d) of this Plan.

(4) *Election of Employee Account Benefit by Regular Beneficiary*. If an Employee qualifies as a Regular Beneficiary under Subsection 2.1(a) hereof and elects an Employee Account benefit pursuant to Subsection 3.3(b) hereof, all Contributions made on the Employee's behalf will be credited to the Employee Account.

(5) *Investment Earnings and Losses on Employee Accounts*.

a. Generally, neither past nor future investment earnings will be added to the Employee Account balance for an Employee who qualifies as a Limited Beneficiary under this Section. Any investment earnings gained or

interest accrued from the Employee Account balance shall be allocated to and applied to, the pooled assets utilized for funding and setting the Plan's Unit Multiplier.

b. However, at the time of establishing an Employee Account pursuant to Subsection 3.3(b) (election of Employee Account benefit by certain Regular Beneficiaries), the Trust Office will calculate and add to (or subtract from) the Employee Account balance the actual past investment earnings (or losses) on Contributions on behalf of the Employee, according to rules set by the Trustees, which were earned (or lost) during the period that the Plan received Contributions on the Employee (including COBRA contributions), until the Trust Office receives an Election Form from the Beneficiary pursuant to Subsection 3.3(b) hereof. No future investment earnings or losses occurring after receipt of the Election Form will be allocated to the Employee Account.

(6) *Benefit Payments*. Benefit payments for Covered Expenses of Limited Beneficiaries are debited from the Employee Account balance.

(7) *Account Administration Fee*. A reasonable Account Administration Fee, as determined by the Trustees pursuant to Subsection 3.5(e) hereof, shall be debited from each Employee Account balance periodically.

2.2 Active Service

(a) Employment with a Participating Employer. Active Service is used to determine an Employee's eligibility for monthly benefits under this Plan. An Employee may earn Active Service in the following ways:

(1) For employment as an Employee with a Participating Employer, after the Employee's Effective Date, provided that Contributions are made to the Trust on the Employee's behalf during that time;

(2) For time as an Employee on any authorized leave of absence from a Participating Employer, including authorized disability, illness, or injury, provided that Contributions are made to the Trust during that time (including periodic self-payment of COBRA contributions); and

(3) For service in the Armed Forces, as required by federal law.

(b) Contribution after Termination or Reduction of Employment (COBRA). An Employee whose employment is terminated or reduced may continue to earn Active Service by periodic self-payment of contributions, for a maximum of eighteen months, pursuant to the federal law known as COBRA and rules set by the Trustees.

(c) Spouse or Child Contribution COBRA Qualifying Event. After the death of an Employee, or the divorce of an Employee or Employee, a Surviving Spouse or Surviving Child may continue to earn Active Service by periodic self-payment of Contributions, for a maximum of thirty-six (36) months, pursuant to the federal law known as COBRA, and rules set by the Trustees. The Surviving Child of an Employee, who experiences a loss of benefits, as either a Regular Beneficiary or Limited Beneficiary, due to exceeding the age requirements for eligibility as a Child, may continue to receive benefits by periodic self-payment of Contributions, for a maximum of thirty-six (36) months, pursuant to COBRA and rules set by the Trustees.

(d) Transfer of Leave. An Employee may earn Active Service Units by transfer of leave accumulation, which includes only sick and/or vacation leave, into the Plan, annually or within ninety (90) days of the Employee's retirement date, provided that:

(1) Such transfer is made pursuant to a non-elective requirement for such transfer in his or her CBA;

(2) The CBA requires conversion into Active Service Units; and

(3) The conversion is done according to a formula set by the Trustees, in consultation with the Trust's actuary, and based on the actual age of the Employee at the date of the transfer, all of which shall be set forth in a "Leave Conversion Table" prepared by the Trust's actuary.

(4) The Leave Conversion Table is set forth in Appendix C, which by this reference is incorporated herein.

2.3 Self-Pay Contributions. Self-payment rules for purposes of Subsections 2.2(b)-(c) shall be set by the Trustee's and may be obtained from the Trust Office.

2.4 No Rebate or Refund. Employees and/or Beneficiaries shall not be eligible for rebates or refunds of any contributions made, except as reimbursement of Covered Expenses. As permitted by applicable law and approved by the Board of Trustees, any elective contributions made (other than pursuant to the federal COBRA law or USERRA) will be refunded within thirty (30) days of discovery that the contribution was made by individual election. Beneficiaries are not entitled to Active Service Units or Active Service based on an elective contribution, regardless of whether the contribution is refunded.

SECTION 3. BENEFITS

3.1 General

(a) Payment of Benefits. An Employee may become a Beneficiary under either Subsections 2.1(a) or 2.1(b), or both. The rules in Sections 3.2, 3.3 and 3.4 apply to Regular

Beneficiaries, i.e., those Employees who become eligible under Subsection 2.1(a). The rules in Section 3.5 apply to Limited Beneficiaries, i.e., those Employees who become eligible under Subsection 2.1(b) for benefits from Employee Accounts. All benefit payments are subject to proper and timely submission of claims pursuant to Section 3.6 hereof.

(b) Recoupment of Overpaid Benefits. If the Trust overpays benefits in regard to a Beneficiary, the Trust Office shall recoup the overpaid amount from the Beneficiary's future benefit payments or request repayment from the Beneficiary, as directed by the Trustees. The Beneficiary shall be obligated to repay the Trust for overpaid benefits, as allowed by law.

3.2 Commencement of Benefits. Benefits for Regular Beneficiaries shall commence as set forth in this Section 3.2.

(a) Regular Beneficiary. A Regular Beneficiary shall be entitled to monthly benefit payments for reimbursement of Covered Expenses upon meeting the eligibility requirements of Subsection 2.1(a).

(b) Surviving Spouse. A Surviving Spouse of a Regular Beneficiary shall be entitled to monthly benefit payments starting the later of: (i) the month after the Regular Beneficiary dies; or (ii) the month that a deceased Regular Beneficiary would have reached the eligibility age set forth in Subsection 2.1(a)(3).

(c) Surviving Children. If there is no Surviving Spouse, then Surviving Child(ren) of a Regular Beneficiary shall be entitled to monthly benefit payments upon death of the Regular Beneficiary, or if applicable, the death of the Surviving Spouse. A Surviving Spouse may submit Covered Expenses of a Surviving Child for reimbursement out of the Surviving Spouse Benefit Level.

(d) Alternate Payee. An Alternate Payee, pursuant to a QDRO, may commence receiving benefits at a time specified in the QDRO, but no earlier than the earliest date the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the Participating Employer on such date. The Surviving Children of the marriage of the Employee and Alternate Payee shall commence receiving benefits based on the Alternate Payee's Benefit Level starting the month after the death of the Alternate Payee.

3.3 Benefit Levels for Regular Beneficiaries. An Employee who becomes a Regular Beneficiary under Subsection 2.1(a), and his or her Surviving Spouse and Children, shall be entitled to monthly reimbursement of Covered Expenses in an amount not to exceed the Regular Beneficiary's Benefit Level, calculated pursuant to this Section.

(a) Regular Beneficiary. The monthly Benefit Level for a Regular Beneficiary shall be determined according to the following methodology:

(1) Determine the number of Active Service Units contributed on behalf of that Regular Beneficiary; and

(2) Multiply the number of Active Service Units by the Unit Multiplier operative on the date the claim is received by the Trust Office, as set forth in Appendix A hereto, which is by this reference incorporated herein, subject to Subsection 3.3(b) hereof.

(b) Regular Beneficiary with Low Benefit.

(1) An Employee who qualifies as a Regular Beneficiary may elect an Employee Account benefit, instead of the monthly benefit calculated pursuant to Subsection 3.3(a), if the Employee Account balance for the Employee calculated pursuant to Subsection 2.1(c) hereof, on the date that he or she attains eligibility in Subsection 2.1(b) and applies for benefits, would be less than $5,000.

(2) The Employee can make this election by signing and submitting an Employee Account Election Form provided by the Trust Office and approved by the Trustees for this purpose, as long as the signed Election Form is received by the Trust Office prior to the first benefit payment.

(3) This is an irrevocable election; upon receipt of the signed Election Form at the Trust Office, the Employee, and his or her Beneficiaries, will become Limited Beneficiaries under this Plan, subject to all the rules of Section 3.5 hereof, and will no longer be Regular Beneficiaries.

(c) Modifications. The Trustees reserve the right and power to modify the Unit Multiplier from time to time, and the new Unit Multiplier may apply to some or all current and/or future Beneficiaries, as determined by the Trustees. The applicable Unit Multiplier and the designation of Beneficiaries to whom it is applicable will be set forth in Appendix A hereto, which is by this reference incorporated herein.

(d) Surviving Spouses and Children.

(1) The Benefit Level for a Surviving Spouse (with or without Surviving Children) shall be 50% of the Benefit Level for the Regular Beneficiary. If there is no Surviving Spouse and there are Surviving Children, the Benefit Level shall be 50% of the Benefit Level for the Regular Beneficiary (to be divided amongst the Children who have submitted claims each month).

(2) If a Regular Beneficiary has accumulated unused benefit amounts pursuant to Subsection 3.3(e) hereof, then the Surviving Spouse shall be entitled to such amounts. If there is no Surviving Spouse, then the Surviving Children shall be entitled to such amounts (to be divided amongst the Children who have submitted claims each month).

(3) If an Employee dies before receiving any benefit payments from this Plan and would have been eligible to make an election under Subsection 3.3(b) if he or she had lived, then the Surviving Spouse can make the election under Subsection 3.3(b) by signing and submitting the Employee Account Election Form to the Trust Office prior to receipt of the first benefit payment by the Surviving Spouse or Surviving Children. The Surviving Spouse will be eligible to make the election in Subsection 3.3(b) on or after the date that the deceased Employee would have attained the eligibility age under Subsection 2.1(a)(2). This is an irrevocable election; upon receipt of the signed Election Form at the Trust Office, the Surviving Spouse and Surviving Children will become Limited Beneficiaries under this Plan, subject to Section 3.5 hereof.

(4) There shall be no survivor benefits for the family or dependents of an Alternate Payee on the death of the Alternate Payee, except that the Children from the marriage of the Employee and Alternate Payee shall continue to have Surviving Child benefits calculated based upon the Benefit Level of the Alternate Payee, which shall commence as stated in Subsection 3.2(d) hereof.

(e) Accumulation of Unused Monthly Benefit Level. The Trust will accumulate any unused portion of the monthly Benefit Level for a Regular Beneficiary for reimbursement of Covered Expenses.

(f) Carry Over of Claims that Exceed the Monthly Benefit Level. The Trust will carry over claim amounts for Covered Expenses that exceed the monthly Benefit Level of a Regular Beneficiary and his or her Beneficiaries; provided, however, that the Trust will not prepay claims. For example, if a Regular Beneficiary has a monthly Benefit Level of $100 and submits a claim for Covered Expenses of $300 in January 2023, then the Trust will reimburse the Beneficiary $100 in January of 2023, $100 in February of 2023 and $100 in March of 2023, i.e., the Trust will not reimburse the Beneficiary $300 in January. (However, if there are new claims in February or March, payment on them will be deferred to April and carried over to subsequent months, as necessary.)

(g) Alternate Payees Under QDROs. The monthly Benefit Level or Employee Account for an Alternate Payee pursuant to a QDRO will be determined as described in this Section. A QDRO may award an Alternate Payee a portion of the Employee's Benefit Level and corresponding ASUs, or Employee Account.

(1) Designation of Portion of Benefit Level and Actuarial Adjustment. A QDRO may designate a fixed amount or a percentage of the Employee's Benefit Level or Employee Account earned during the marital period, as defined in the QDRO, to the Alternate Payee. No other method of division of the Employee's monthly benefit shall be permitted. The Trust Office, in consultation with the Plan's actuary, shall convert the Benefit Level thus designated for the Alternate Payee into an actuarially adjusted Benefit Level of the Alternate Payee, based on the Alternate

Payee's age and the month that commencement of benefits is first available to the Alternate Payee.

(2) Modification of Alternate Payee Benefit Level. The Benefit Level of the Alternate Payee shall change from time to time, based on changes to the Unit Multiplier and otherwise, in the same manner and percentage as the Employee's monthly benefit changes. These changes may occur before or after the commencement of benefit payments to the Alternate Payee.

3.4 Termination of Benefits. Benefits for Regular Beneficiaries shall terminate as set forth in this Section 3.4.

(a) Regular Beneficiary.

(1) Generally. The monthly benefit coverage for a Regular Beneficiary under the Plan shall terminate on the date of the Regular Beneficiary's death; provided however that claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Regular Beneficiary after death, will be paid for the months through and including the month in which the Regular Beneficiary died, at the rate of the monthly Benefit Level for that Regular Beneficiary.

(2) Return to Employment. The monthly benefit coverage for a Regular Beneficiary under the Plan shall be suspended on the date that the Regular Beneficiary again becomes employed by a Participating Employer; Upon cessation of all employment with all Participating Employers, benefit payments shall resume. A Surviving Spouse, who is also an Employee, shall be eligible to receive Surviving Spouse benefits regardless of employment with the Participating Employer.

(b) Surviving Spouse and Children. The monthly benefit coverage of the Surviving Spouse or Surviving Child(ren) of a Regular Beneficiary shall terminate as follows:

(1) *Surviving Spouse*. The monthly benefit coverage for a Surviving Spouse shall terminate on the date of the Surviving Spouse's death; provided, however, that claims for Covered Expenses which are properly and timely submitted on behalf of the deceased Surviving Spouse after death, will be paid for the months through and including the month in which the Surviving Spouse died, at the rate of the monthly Benefit Level for that Surviving Spouse.

(2) *Surviving Child(ren)*. If there is no Surviving Spouse, Surviving Child(ren) shall be entitled to the benefits until loss of Child(ren) status, as defined in Section 1.4 hereof.

(c) Alternate Payees Under QDROs. The benefits for an Alternate Payee under a QDRO shall terminate on the first of the month following the date of the Alternate Payee's

death. An Alternate Payee's benefit shall not be suspended if the Employee on whom it is based returns to employment with a Participating Employer.

(d) Modifications to Benefits. Benefit coverage may be modified or terminated pursuant to Section 6 hereof, and such changes may apply to current and/or future Beneficiaries.

3.5 Benefits from Employee Accounts

(a) Employee Account Benefit Payments. An Employee who becomes a Limited Beneficiary under Subsection 2.1(b) hereof, and his or her Beneficiaries, are entitled to reimbursement of Covered Expenses from the Employee's Employee Account balance, pursuant to Section 2.1(c) hereof.

(b) Benefit Level. There shall be no maximum on a claim against the Employee Account, so long as all claims are for reimbursement of Covered Expenses, and the balance in the Employee Account is sufficient to satisfy the claims. The monthly Unit Multiplier calculation does not apply to Employee Accounts.

(c) Commencement and Termination of Benefits from Employee Account.

(1) *Limited Beneficiary who was an Employee*. Reimbursement from the Employee Account for a Limited Beneficiary who was an Employee may commence after termination of employment with a Participating Employer, and will terminate when the Employee Account balance reaches zero. If the Limited Beneficiary returns to employment (including per diem employment) with a Participating Employer, this benefit shall be suspended until termination of such employment.

(2) *Surviving Spouse*. The Surviving Spouse of a deceased Limited Beneficiary is entitled to reimbursement benefits of Covered Expenses following the death of the Limited Beneficiary until the Employee Account balance reaches zero. The Surviving Spouse may submit claims to use the Employee Account balance for reimbursement of Covered Expenses of Surviving Children.

(3) *Surviving Children*. If there is no Surviving Spouse, the Surviving Child(ren) of the deceased Limited Beneficiary is entitled to reimbursement benefits of Covered Expenses following the death of the Limited Beneficiary, or the Surviving Spouse, as applicable. Coverage of the Surviving Child(ren) will terminate on the date that the last Surviving Child no longer meets the definition of Child under the Plan. Any balance remaining upon the death of the Surviving Children, or at the time the last Surviving Child no longer meets the definition of Child under the Plan, shall forfeit to the Plan.

(4) *Forfeiture*. Any balance left in the Employee Account upon the death of the Beneficiary and his or her surviving Beneficiaries will forfeit to the Plan.

(d) Modification of Rules. The Trustees may modify or amend the rules for benefit payments from Employee Accounts, which may apply to current and/or future Beneficiaries.

(e) Account Administration Fee. The Trustees may set policies and procedures to establish a reasonable Account Administration Fee, which shall be debited from each Employee Account balance periodically, as determined by the Trustees, and transferred to the general pooled account, to pay a proportionate share of the operating expenses to administer Employee Accounts for Beneficiaries with no other benefits from the Plan. If an Employee is both a Regular Beneficiary and a Limited Beneficiary, then the Account Administration Fee shall not apply to his or her Employee Account.

3.6 Benefit Claim Procedure

(a) To make a claim for Plan benefits, Beneficiaries must present independent documentation of the following to the Trust Office:

(1) The date the medical services or supplies were provided (which date must be prior to submission of the claim), or the dates of coverage for insurance premium;

(2) The medical services or supplies, as defined in Subsection 1.8(b) hereof, or insurance premiums, as defined in Subsection 1.8(a) or (c) hereof; and

(3) The Beneficiary's payment of the Covered Expenses.

Along with the above documentation, Beneficiaries must submit a completed claim form, approved by the Trustees, to the Trust Office. Prior to issuing payment, the Trust Office shall review such documentation and claim form and determine whether to grant or deny coverage under the Plan. Documentation must be submitted for each medical expense reimbursement claim under Subsection 1.8(b) hereof. See Subsection 3.6(c) below for frequency of documentation of recurring premium claims under Subsections 1.8(a) and (c).

(b) Proof of payment of a Covered Expense shall include, but not be limited to, canceled checks drawn to the name of the medical insurance or service provider, or receipt for payment from the medical insurance or service provider, or bank statement or credit card statement showing payment to the medical insurance or service provider, subject to verification as determined by the Trustees in their sole discretion.

(c) Documentation for Reimbursement of Recurring Monthly Premiums. For reimbursement of recurring monthly premium payments:

(1) At least annually, the Beneficiary must submit to the Trust Office the completed claim form, signed by the Beneficiary, and documentation that satisfies the requirements of Subsection 3.6(a).

(2) For each monthly premium reimbursed, except Medicare premiums reimbursed pursuant to Subsection (3) below, the Trust Office must receive documentation that satisfies the requirements of Subsection 3.6(b) showing proof of the Beneficiary's payment of the same monthly premium that the Beneficiary claimed and documented pursuant to the annual documentation requirements in Subsection (1) above.

(3) For reimbursement of recurring monthly Medicare premiums, the Trust Office must receive at least once a year, and upon request, the completed and signed claim form of the Trust and the Beneficiary's annual Social Security Administration statement showing the amounts deducted from the Beneficiary's social security payments, or otherwise paid by the Beneficiary, for Medicare premiums.

(d) Beneficiaries may submit claims for reimbursement of Covered Expenses, in the order described below:

(1) Employee. Subject to Subsection (4) below, only an Employee may submit claims for reimbursement of Covered Expenses of a Beneficiary in his or her family.

(2) Surviving Spouse. Subject to Subsection (4) below, after the death of the Employee, only a Surviving Spouse may submit claims for reimbursement of Covered Expenses of a Beneficiary.

(3) Surviving Children. If there is no Surviving Spouse, a Surviving Child, or his or her legal guardian, may submit claims for reimbursement of his or her own Covered Expenses.

(4) Delegation of Authority to Submit Claims. An Employee or Surviving Spouse may delegate authority to submit claims to a family member by completing and submitting to the Trust Office a form approved by the Trustees for that purpose.

(5) Revocation of Authority to Submit Claims. An Employee or Surviving Spouse may revoke authority granted pursuant to Subsection 3.6(d)(4) hereof at any time by submitting a written revocation (including via email) to the Trust Office.

(6) Alternate Payee. An Alternate Payee shall have authority to submit claims for Covered Expenses of Children from the marriage of the Employee and Alternate Payee.

(e) If the Trust Office denies coverage, in whole or part, on the Beneficiary's claim or the Plan takes other action adverse to the Beneficiary, the Beneficiary may appeal the denial of coverage or any other adverse benefit determination of the Plan, by taking action pursuant to Section 4.3 hereof.

(f) Claims for Plan benefits should be submitted within three months after end of the plan year in which the expense was paid. However, the Trust Office may waive the deadline for good cause shown, according to guidelines set by the Trustees.

(g) If the Trust Office grants coverage on the Beneficiary's claim, all Plan benefits are personal to the Beneficiary and payable only to the Beneficiary, except as provided in Subsection 3.6(h) regarding Beneficiary deemed to be incompetent, or pursuant to a QDRO or QMCSO under federal law. If the Trust Office denies coverage, in whole or part, on the Beneficiary's claim, or the Plan takes other action adverse to the Beneficiary, the Beneficiary may appeal the denial of coverage or any other adverse determination of the Plan, by taking action pursuant to Section 4.3 hereof.

(h) If a Beneficiary is deemed to be incompetent by a lawful judicial forum, then the Trust Office may pay any benefit claims payment to the person that the judicial forum has appointed as the Beneficiary's representative, and the Beneficiary's representative may submit claims and take action on the Beneficiary's behalf, subject to the requirements of this Section 3.6. The Trustees shall not be under any duty to oversee the application of funds so paid, and receipt by the Beneficiary's representative shall be full acquittance to the Trustees, the Trust Office, and the Plan.

(i) A Beneficiary or Employee who does not have a claim for current Covered Expenses, but seeks to enforce his or her rights under the terms of the Plan or seeks to clarify his or her rights to future benefits or eligibility under the terms of the Plan, may submit a written request to the Trust Office explaining his or her position and asking for a decision or clarification. The Beneficiary or Employee should enclose any relevant documentation supporting the request. If the Beneficiary or Employee is not satisfied with the decision of the Trust Office, the Beneficiary or Employee may request an appeal of the Trust Office decision to the Board of Trustees pursuant to Section 4.3 hereof.

3.7 Prohibition of Assignment and Protection from Creditors

(a) No Assignment or Encumbrance of Benefits. No benefit payment under this Plan shall be subject in any way to assignment, alienation, sale, transfer, pledge, attachment, garnishment, or encumbrance of any kind. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish, or encumber the benefits or monies due from this Plan, whether for current or future benefits, shall be void. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any right or interest under this Plan for part or all of the Employee's or

Beneficiary's current or future benefit payments. Any such arrangement shall be void under this Plan.

(b) No Assignment of Rights Under Law. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish or encumber the Employee's or Beneficiary's rights under this Plan shall be void, including but not limited to, the right to bring any action in court, file a lawsuit or appeal a coverage determination, the right to enforce rights or eligibility under the Plan, the right to benefits or eligibility under the Plan, the right to clarify rights to future benefits or eligibility under the Plan, and the right to request copies of Plan documents or annual reports. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any such right. Any such arrangement shall be void under this Plan.

(c) Protection of Benefits from Creditors. The Plan and Trust Fund are exempt from all claims from creditors or other claimants and from all orders, decrees, garnishments, executions, and legal processes or proceedings, except in connection with qualified medical child support orders or qualified domestic relations orders.

SECTION 4. CLAIM APPEAL PROCEDURES

4.1 Beneficiary's Duty to Notify Trust Office of Claim. The Beneficiary is required to notify the Trust Office of his or her claim for benefits pursuant to Section 3 hereof, before he or she is entitled to either receive benefits under this Plan, or appeal the Trust Office's decision denying a request for benefits.

4.2 Acceptance or Denial of Claims by the Trust Office.

(a) Standard Claim Decision – Timing. The Trust Office shall consider each claim for Plan benefits and determine whether to grant or deny coverage under the Plan. Subject to Subsections 4.2(b) and 4.2(c) hereof, the Trust Office shall send written notification of a denial not later than thirty (30) calendar days after receipt of the Beneficiary's claim. If coverage is granted, the Beneficiary shall receive payment as stated in Subsection 3.6(d) hereof. If the claim is denied, the Beneficiary has the right to appeal the claim pursuant to Section 4.3 hereof and the Plan's "Appeal Procedures," if any, available from the Trust Office.

The denial notification shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) A description of any additional material or information necessary for the Beneficiary to perfect the claim and an explanation of why such material or information is necessary;

(4) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request;

(5) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary's claim for benefits; and

(6) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits, the time limits applicable to such procedures, and a statement of the Beneficiary's right to bring an action in court after exhaustion of administrative procedures.

(b) Extension of Time – Special Circumstances. If the Trustees determine that special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the Beneficiary prior to the termination of the initial 30 calendar day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trustees expect to render a benefit determination. In no event shall such extension exceed a period of 15 calendar days from the end of the initial period (45 calendar day total).

(c) Extension of Time – Failure to Submit Information. The period of time for the Trustees to make a benefit determination may be extended if the Beneficiary fails to submit all necessary information to allow the Trustees to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Beneficiary until the date the Beneficiary provides to the Trust Office the requested information. The Beneficiary shall be allowed at least 45 calendar days from receipt of the request for additional information within which to provide the information.

4.3 Appeal Procedures. The Trustees, Beneficiaries, and any person who claims to be entitled to benefits under this Plan shall follow the provisions of this Section 4.

(a) Exclusive Procedures. The procedures specified in this Section, together with any written hearing procedures adopted by the Trustees, shall be the exclusive procedures available to a person dissatisfied with an eligibility determination, benefit claim decision or response to written request pursuant to Subsection 3.6(i) hereof, or to a person who is otherwise adversely affected by any action of the Trustees.

(b) Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in

writing within 181 calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes that the grounds for denial of benefits are inapplicable. The Beneficiary may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for benefits to the Trustees. The Beneficiary shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Beneficiary's claim for benefits.

(c) Decision on Appeal. The Trustees shall make decision, affirming, modifying or setting aside the former decision, no later than the date of the meeting of the Board of Trustees that immediately follows the Trust Office's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, the Trustees shall make a decision no later than the date of the second meeting following the Trust Office's receipt of a request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be made no later than the third meeting of the Trustees following the Trust Office's receipt of the request for review, provided that the Trust Office provides the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trust Office shall notify the claimant of the decision on appeal as soon as possible, but not later than 5 days after the benefit determination is made. The Trustees may issue a written decision within thirty days thereafter, unless special circumstances require another thirty day extension. Any notification of a denial of benefits shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Beneficiary's claim for benefits;

(4) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request;

(5) An explanation of the Beneficiary's right to bring an action in federal court, after exhaustion of the Plan's administrative procedures; and

(6) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

4.4 Right to Court Review, Time Limit to Bring Lawsuit

(a) General. Upon exhaustion of these procedures in this Section 4, a Beneficiary who is dissatisfied with an eligibility determination, benefit award or response to written request pursuant to Subsection 3.6(i) hereof may bring an action in federal court pursuant to ERISA Section 502(a).

(b) Limitation Period for Filing a Lawsuit Against the Trust for Benefit Payments. A Beneficiary has the right to bring action as described in Subsection 4.4(a) hereof in federal court, pursuant to ERISA Section 502(a), no later than one year after the exhaustion of administrative remedies, which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim, or other complaint described in Subsection 4.4(a).

SECTION 5. MISCELLANEOUS

5.1 Limitation of Rights. Neither the establishment of the Plan and the Trust, nor any modifications thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving any Beneficiary or other person any legal or equitable right of action, or any recourse against any Local, the HPAE or its employees, any Employer or its employees, the Trust or its employees, the Trust Office or the Trustees, except as provided in this Plan and the Trust Agreement.

5.2 Applicable Laws and Regulations. Reference in this Plan to any particular sections of any local, state, or federal statute shall include any regulation pertinent to such sections and any subsequent amendments to such sections or regulations.

5.3 Confidentiality. It is agreed and understood that each Beneficiary who applies for benefits under this Plan is entitled to the same rights and consideration, including the right of confidentiality, and the Trustees shall not be required to nor shall they reveal to any other persons, including the HPAE, its officers, agents or employees, any matters revealed to them in confidence by such Beneficiary in the course of his or her application for benefits, except to the extent required by law. This Plan is subject to the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which imposes specific restrictions on the use and disclosure of protected health information.

5.4 Trustee Authority. The Trustees shall have the authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of this Trust and 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 shall be binding and conclusive.

5.5 Divorce and Court Orders: QDRO and QMCSO Review Costs. The Trust reserves the right to deduct the reasonable costs associated with determining whether a domestic relations

order qualifies as a QDRO, or a medical child support order qualifies as a QMCSO, from the benefits payable to the Employee or Beneficiary, according to rules set by the Trustees.

5.6 Missing Participant Policies and Procedures. The Trustees shall establish policies and procedures for searching for Missing Participants and shall transmit those policies and procedures to the Trust Office. Each Employee and Beneficiary in this Plan has the duty to inform the Trust Office of changes in his or her contact information, including but not limited to, mailing address, cell phone number, and personal email address.

5.7 Right of Subrogation

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(1) Award. "Award" means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual's illness, injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(2) Covered Individual. "Covered Individual" includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.

(3) Reimbursement. "Reimbursement" means the Plan's right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the illness, injury or other loss that resulted in the payment of such benefits by the Plan.

(4) Subrogation. "Subrogation" means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual's lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual's illness, injury or other loss that resulted in a payment of benefits by the Plan.

(5) Third Party. "Third Party" includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the illness, injury or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of illness, injury or other loss, the Plan shall have the following rights:

(1) Subrogation to any and all rights of recovery the Covered Individual may have arising from such injury, illness or other loss;

(2) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of injury, illness or other loss with respect to which the Plan has a right to subrogation pursuant to paragraph (1) above from any award arising out of such injury, illness or other loss; and

(3) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual's immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such illness, injury or other loss with respect to which the Plan has a right to subrogation pursuant to paragraph (1) hereof and a right to reimbursement pursuant to paragraph (2) hereof but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan's subrogation/reimbursement/benefit offset rights (herein referred to collectively as "Recovery Rights") shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any award paid to or for the benefit of the Covered Individual. The Plan does not recognize the "make whole" rule and a Covered Individual may not be whole after the Plan's Recovery Rights are satisfied.

(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any illness, injury or other loss that a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any award from any Third Party. However, subject to the terms and conditions of this Section 5.7, the Plan will make advance payment of benefits in accordance with the terms of the Plan, until an award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such illness, injury or loss or until it is determined whether there will be an Award.

By accepting an advance payment of benefits from the Plan (including by accepting benefits that are or may be subject to the Plan's rights under this Section 5.7 prior to notification to the Plan of the possibility of a Third Party liability), the Covered Individual(s) jointly and severally agree that:

(1) the Plan has a priority lien against any award paid to or on behalf of the Covered Individual to assure that reimbursement is promptly made; and

(2) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and

(3) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all awards paid or payable to such Covered Individual(s) by any

Third Party to the extent of the Plan's advance payment of benefits for claims related to the illness, injury or other loss; and

(4) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any Workers' Compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan (including without limitation any and all payments made prior to being notified of the possibility that a Third Party might have liability).

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's illness, injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim is or may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a representation and explanation from the Covered Individual that there is no possibility of a Third Party having liability.

(f) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits, the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(1) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's illness, injury or other loss that resulted in the Plan's advance payment for benefits; or

(2) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's illness, injury or other loss that resulted in the Plan's advance payment for benefits related to such illness, injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee, informed of all material developments with respect to all such claims, actions or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

(g) All Recovered Proceeds are to be Applied to Reimburse the Plan.

(1) Except as otherwise specifically agreed to by the Plan Administrator, the Plan's Recovery Rights are to 100% of the gross proceeds recovered for or on behalf of the Covered Individual, without reduction for attorney's fees, other litigation expenses, or other losses of the Covered Individual, to the extent needed to fully reimburse the Plan for its advances and for any other amounts it is contemplated that the Plan will pay towards the illness or injury in question.

(2) By accepting an advance payment of benefits for an illness, injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any award paid or payable to or on behalf of such Covered Individuals by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

(3) If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

(4) Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an illness, injury or other loss with respect to which an award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the award was reasonable and the subsequent claims were not recognized in the award.

(5) In its sole discretion, in situations where the Plan's claim against an Award would otherwise not leave funds to permit the payment of attorney's fees or other litigation expenses or to remedy other direct economic losses of the Covered Individual, the Plan Administrator may agree to a proration or offset of all or part of the Covered Individual's attorney's fees and expenses of litigation and/or to a reduction of the Plan's claim to reflect other direct economic losses of the Covered Individual. Any such agreement by the Plan Administrator shall be on such conditions as the Plan Administrator shall specify, and any such forbearance agreed to by the Plan Administrator shall be nullified if such conditions are not promptly and fully complied with. Such an agreement by the Plan Administrator may occur at the outset of the Covered Individual's efforts to recover from the liable (or allegedly liable) Third Party or at any time thereafter. Each such agreement by the Plan Administrator shall be based solely on the facts and circumstances of the specific claim, and shall be limited to the Covered Individual in question and shall not create a precedent on which other Covered Individuals could rely regarding other Third Party Awards.

(h) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan's Recovery Rights.

SECTION 6. AMENDMENTS AND TERMINATION

6.1 In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources and applicable law, a Plan dedicated to providing benefits for Beneficiaries, the Trustees expressly reserve the right, in their sole discretion, at any time and from time to time, provided that such action does not violate federal discrimination law:

(a) To modify the Benefit Amounts.

(b) To amend or rescind any provision of this Plan.

(c) To terminate the Plan.

Any such changes may apply to some or all current and/or future Employees or Beneficiaries, as determined by the Board of Trustees. Amendments shall be made by action of the Board of Trustees pursuant to Article 4 of the Trust Agreement.

SECTION 7. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

7.1 General. This Plan is subject to the Privacy Rule, as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The HIPAA Privacy Rule sets forth standards to ensure that personal health information is kept private. This Section describes the

conditions under which the Plan may disclose Protected Health Information ("PHI") to the Board of Trustees, and the permitted and required use of such information by the Trustees. For purposes of this Section, the term Protected Health Information or PHI shall have the meaning provided in 45 CFR § 160.103.

7.2 Disclosure to the Board of Trustees

(a) Permitted Disclosure of Summary Health Information. Summary Health Information is information that summarizes claims history, claims expenses, or type of claims experienced by individuals for whom the Plan has provided benefits, which excludes all demographic information that identifies individual Beneficiaries or could reasonably be used to identify an individual Beneficiary. The Trust Office, on behalf of the Plan, may disclose Summary Health Information to the Board of Trustees for the purposes of modifying amending or terminating this Plan.

(b) Permitted Disclosure of Individual Participation or Enrollment Status. The Trust Office, on behalf of the Plan, may disclose to the Board of Trustees information on whether an individual is participating or enrolled in the Plan.

(c) Permitted Disclosure of PHI. The Plan may disclose PHI to the Board of Trustees in order for the Trustees to carry out plan administration functions for this Plan.

(d) Conditions for Disclosure of PHI to Board of Trustees. The Board of Trustees agrees that all Trustees individually, or the Trust Office on behalf of the Board of Trustees, will take, or avoid, the following actions regarding the use of PHI disclosed to the Board of Trustees:

(1) To not use or further disclose PHI other than as permitted or required by this Plan, or as required by law.

(2) To ensure that any agents of the Plan and Trust, including independent contractors and subcontractors, to whom the Trustees and Plan provides PHI, agree to restrictions and conditions required by federal law with respect to PHI.

(3) To not disclose PHI to Employers or Associations for employment related actions and decisions or in connection with any other benefit or employee benefit plan.

(4) To report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the Plan or federal law, of which the Trustees become aware.

(5) To make available to individual Plan participants access to their own PHI, amendment to their own PHI, and accounting of disclosures of PHI, to the extent required by 45 CFR § 164.524 and 164.526.

(6) To make internal practices, books, and records relating to the use and disclosure of PHI, received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR § 164.504(f).

(7) Return or destroy all PHI received from the Plan that the individual Trustees maintain in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made.

(8) To limit the access and use of PHI to plan administrative functions for this Plan.

7.3 Security of Electronic PHI. The Board of Trustees shall reasonably and appropriately safeguard electronic PHI created, maintained, or transmitted to or by the Board of Trustees on behalf of the Plan. The Board of Trustees will:

(a) Agents and Subcontractors. Ensure that the Trust Office, and any agent of the Trust or Plan, including a subcontractor, to whom the Plan provides PHI, agrees to implement reasonable and appropriate security measures to protect the information and comply with federal law.

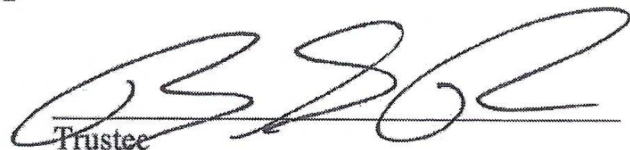
(b) Transmission and Maintenance of Electronic PHI. Implement processes that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI created, received, maintained or transmitted on behalf of the Plan to the Trustees.

(c) Trustee Duty to Report Incidents. Report appropriately any security incident of which the Trustees become aware.

Adopted at a Board of Trustees meeting held on the 27th day of February, 2023 and effective March 1, 2023.

For the **BOARD OF TRUSTEES,**
HEALTH PROFESSIONALS AND ALLIED EMPLOYEES,
AFT/AFL-CIO RETIREE MEDICAL TRUST

Chairman, Board of Trustees



Trustee

APPENDIX A
UNIT MULTIPLIER

Operative Period**	Unit Multiplier*
August 1, 2014 – June 30, 2022	$0.07
July 1, 2022 – present	$0.075

** The Unit Multiplier (UM) is a factor in the calculation of the monthly Benefit Level for a Regular Beneficiary (see Section 3.3 of the Plan).*

*** The UM applies to claims received by the Trust Office during the Operative Period; provided, however, that the Trustees may modify the UM for some or all current and/or future Beneficiaries from time to time. Also, the amount paid by the Trust may not exceed the actual Covered Expenses paid by the Beneficiary.*

APPENDIX B
EXAMPLES OF BENEFIT LEVEL CALCULATION

Every \$5.00 in Contributions = 1 Active Service Unit (So \$0.20 contribution = 1/25th of an ASU; and \$0.25 contribution = 1/20th of an ASU.) Assume Unit Multiplier= \$0.075

<u>Example #1 – 6 years in Trust</u>: Assume a Local has a contribution rate of \$0.20/hour worked, and Employee Jones works 2,000 hours per year for two years with that contribution rate. Then the Local increases the contribution rate to \$0.25/hour worked, and Jones works 2,000 hours per year for four more years with that contribution rate, and then retires. The monthly amount available to Jones for medical expense reimbursement will be calculated as follows:

Step 1: Convert hourly contributions to Active Service Units (ASUs)
\$0.20/hour = 1/25 Active Service Unit/Hour
\$0.25/hour = 1/20 Active Service Unit/Hour

Step 2: Find total number of Active Service Units (ASUs) earned
1/25 ASU/hour x 2,000 hours/year x 2 years = 160 ASUs
1/20 ASU/hour x 2,000 hours/year x 4 years = 400 ASUs
Total = 560 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier:
Monthly Benefit Level: 560 x \$0.075 = \$42.00
Annual Benefit: \$504.00

<u>Example #2 – 12 years in Trust</u>: A Local selects a contribution rate of \$0.20/hour, and Employee Jones works 2,000 hours per year for seven years with that contribution rate. Then the Local increases the contribution rate to \$0.40/hour, and Jones works 2,000 hours per year for five years at that level, and then retires. The monthly amount available to Jones for medical expense reimbursement will be calculated as follows:

Step 1: Convert hourly contributions to Active Service Units (ASUs)
\$0.20/hour = 1/25 Active Service Unit/Hour
\$0.40/hour = 2/25 Active Service Unit/Hour

Step 2: Find total number of Active Service Units (ASUs) earned
1/25 ASU/hour x 2,000 hours/year x 7 years = 560 ASUs
2/25 ASU/hour x 2,000 hours/year x 5 years = 800 ASUs
Total = 1360 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 1360 x \$ 0.075 = \$102.00
Annual Benefit: \$1,224.00

Example #3 – Career Employee – 25 years in Trust: A Local selects a contribution rate of $0.20/hour, and Employee Jones works 2,000 hours per year for seven years with that contribution rate. Then the Local increases the contribution rate to $0.40/hour, and Jones works 2,000 hours per year for 18 years at that level, and then retires. The monthly amount available to Jones for medical reimbursement will be calculated as follows:

Step 1: Convert hourly contributions to Active Service Units (ASUs)
$0.20/hour = 1/25 Active Service Unit/Hour
$0.40/hour = 2/25 Active Service Unit/Hour

Step 2: Find total number of Active Service Units (ASUs) earned
1/25 ASU/hour x 2,000 hours/year x 7 years = 560 ASUs
2/25 ASU/hour x 2,000 hours/year x 18 years = 2880 ASUs
Total = 3440 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 3440 x $ 0.075 = $ 258.00
Annual Benefit: $3,096.00

* * *

Please note: Trustees work with a professional actuarial firm to determine the UM. The Trustees reserve the right to modify the UM and the formula used to calculate Benefit Levels at any time for some or all existing and/or future Beneficiaries. For more details, please contact the Trust Office.

APPENDIX C
LEAVE CONVERSION TABLE

- For Employees who convert Leave Transfer on and after October 1, 2016,the Trust Office shall use the following Table to determine the number of ASUs earned from the conversion.

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

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

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

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

- **The third column of this leave conversion table assumes a leave transfer of $1,000**.

Age at Leave Transfer	Cost for One Active Service Unit in dollars and cents ("x")	Number of ASUs Earned with $1000 ($1,000 / x) (rounded to nearest whole number)
Age 20	1.56	641
Age 21	1.66	602
Age 22	1.76	568
Age 23	1.86	538
Age 24	1.97	508
Age 25	2.09	478
Age 26	2.22	450
Age 27	2.35	426
Age 28	2.49	402
Age 29	2.64	379
Age 30	2.80	357
Age 31	2.97	336
Age 32	3.14	318
Age 33	3.33	300
Age 34	3.53	283

Age at Leave Transfer	**Cost for One Active Service Unit in dollars and cents ("x")**	**Number of ASUs Earned with $1000 ($1,000 / x) (rounded to nearest whole number)**
Age 35	3.74	267
Age 36	3.97	252
Age 37	4.21	238
Age 38	4.46	224
Age 39	4.73	211
Age 40	5.01	200
Age 41	5.31	188
Age 42	5.63	178
Age 43	5.97	168
Age 44	6.33	158
Age 45	6.71	149
Age 46	7.11	141
Age 47	7.54	133
Age 48	7.99	125
Age 49	8.47	118
Age 50	8.97	111
Age 51	9.51	105
Age 52	10.08	99
Age 53	10.69	94
Age 54	11.33	88
Age 55	12.01	83
Age 56	11.87	84
Age 57	11.73	85
Age 58	11.58	86
Age 59	11.42	88
Age 60	11.25	89
Age 61	11.08	90
Age 62	10.90	92
Age 63	10.72	93
Age 64	10.52	95
Age 65	10.32	97
Age 66	10.12	99
Age 67	9.91	100
Age 68	9.69	103
Age 69	9.47	106
Age 70	9.24	108