SUMMARY PLAN DESCRIPTION

For the

MEDICAL EXPENSE REIMBURSEMENT PLAN

OF THE

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

Issue Date: December 1, 2023

Dr. 11/21/23
(based on Plan eff 3/1/23
As amended through Am. No. 15)

HIGHLIGHTS OF THE PLAN

- **Eligibility**. Generally, you will need to participate for five years in the Plan to be eligible for monthly benefit payments from the Trust. However, there are limited benefits for shorter participation.

- **Benefits**. Your benefits from this Trust come in the form of reimbursement payments for certain medical costs, which are called "Covered Expenses,"[1] incurred after you retire. There are different levels of benefit payments, depending on how long you were in the Plan.

- **Changes of Employment Status, Address, Spouse or Child(ren)**. Please notify the Trust Office of changes to your employment status or any significant life event that you think might affect your participation in the Trust. For example, if you retire or otherwise separate from employment, you might be entitled to begin receiving benefits, or to make self-pay Contributions under COBRA. If there is a change in mailing address or family composition (i.e., marriage, divorce, or birth of a child), failure to notify the Trust Office may result in loss or delay of benefit payments.

- **Claims**. You must present your claims to the Trust Office with your proof of payment of Covered Expenses, on a form approved by the Trustees, within three months after the end of the Plan year (December 31) in which you incurred the Covered Expense.

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

Health Professionals and Allied Employees, AFT/AFL-CIO
Retiree Medical Trust
c/o Zenith-American Solutions
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534

Phone: (201) 947-8000 HpaermtClaims@Zenith-American.com

***Important Note*: The questions and answers in this Summary Plan Description ("SPD") have been designed to provide you with key information about the HPAE Retiree Medical Trust, but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Medical Expense Reimbursement Plan of the Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust," restated and effective March 1, 2023, as amended (the "Plan"). If there is a conflict between what is contained in the Plan and what is contained in the SPD or any other descriptions, the terms of the Plan will prevail.**

[1] Capitalized terms contained herein are defined in the formal Plan document, and many are described in the Summary Plan Description.

TABLE OF QUESTIONS

PART 1
PARTICIPATION

- **Who can participate in the HPAE Retiree Medical Trust?**

  Participation in the Trust is generally open to all Employees who are members of a bargaining unit represented by a participating HPAE Local and for whom Contributions are made as required by the Local's Collective Bargaining Agreement.

PART 2
CATEGORIES OF BENEFICIARIES AND BENEFITS

- **What are the two categories of Beneficiaries?**

  The Plan provides for two categories of Beneficiaries: "Regular Beneficiaries" and "Limited Beneficiaries." It is possible to belong in one or both of these categories.

  A "Regular Beneficiary" is entitled to monthly benefit payments for life[2] at a certain set monthly amount, in reimbursement for Covered Expenses as defined in the Plan, because he/she met the eligibility requirements listed in Part 3 hereof.

  A "Limited Beneficiary" is entitled to benefit payments in miscellaneous amounts for reimbursement of Covered Expenses from his/her individual Employee Account as needed, up to the balance in the Employee Account. These reimbursements may not last for life if the Employee Account is exhausted. An Employee will have an Employee Account if one of the circumstances listed in Part 4 hereof applies to him or her.

  Benefit payments in both categories reimburse you for the same types of medical expenses, called Covered Expenses under the Plan, after you retire.

  Cost Sharing. It is important to remember that neither your regular monthly benefit payment, nor your Employee Account balance, may cover the entire Covered Expense amount. If your benefit payments from the Plan do not cover the entire cost of your Covered Expense, you will be responsible for the remainder.

- **What medical expenses will be reimbursed by the Plan?**

  The following medical expenses are considered Covered Expenses, under the Plan, when they are incurred for a Beneficiary (Regular Beneficiary, Limited Beneficiary, spouse, Child, and

[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.

Surviving Spouse and Surviving Children, as defined in the Plan).

1. Premium or contribution payments for coverage under health, dental, or vision insurance plans that you pay out-of-pocket and that are tax-deductible. Premiums that you pay pre-tax (i.e., the premium amount was deducted from your income prior to taxation) are not eligible for reimbursement through the Plan.

2. Medical expenses excludable from gross income under Internal Revenue Code Section 213(d), in other words, costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs. For a complete list, see IRS Publication 502, which can be found at **www.irs.gov/pub/irs-pdf/p502.pdf**.

3. Premium payment for tax-deductible qualified long-term care (LTC) insurance.

See Plan Section 1.8 or consult the Trust Office for more details.

PART 3
MONTHLY BENEFITS

- **How do I become a Regular Beneficiary, eligible for regular monthly benefits?**

  An Employee generally becomes a Regular Beneficiary entitled to lifetime monthly benefits[3] after meeting all of the following requirements:

  1. He/she earns five (5) years of Active Service in the Trust;

  2. Contributions are made to the Trust on his/her behalf;

  3. He/she attains age 55; and

  4. He/she ceases all employment (including per diem employment) with a Participating Employer in the Trust.

- **Will I qualify for lifetime monthly benefits as a Regular Beneficiary if I leave my job before I contribute to the Trust for five years?**

  No. An Employee who does not meet the minimum Active Service requirement of five years will generally not qualify for lifetime[4] monthly benefits as a Regular Beneficiary. However,

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

[4] See footnote 3.

such an Employee is eligible for certain benefits as a Limited Beneficiary from his/her Employee Account. (See Part 4 of this SPD for more information on Employee Account Benefits.)

- **How do I earn Active Service? What is the difference between "Active Service" and "Active Service Units"?**

  An Employee may earn Active Service in the following ways:

  Contributions to the Trust. On or after August 1, 2014, an Employee earns one year of Active Service in any calendar year that the Employee works at least 850 hours for which Contributions are made to the Trust.

  COBRA: Contributions after Termination or Reduction of Employment. If your employment is terminated (except for gross misconduct) or reduced, you may continue to earn Active Service for a maximum of eighteen months, by making periodic self-payments to the Trust as permitted by the federal law known as COBRA,[5] and subject to rules set by the Trustees.
  (If continued self-payment enables an Employee to reach the minimum requirement of five years of Active Service, the Employee will become a Regular Beneficiary. If the continued self-payment does not enable an Employee to reach the minimum requirement of five years of Active Service, the value of the self-payments will be added to his/her Employee Account. See Part 4 below.)

  Note the difference between "Active Service" and "Active Service Units" (or ASUs):

  1. Active Service means periods of employment when your employer transferred Contributions to the Trust on your behalf. Your length of Active Service is one of the factors that determines your eligibility for monthly benefits as a Regular Beneficiary.

  2. Active Service Units means the number of $0.05 Contributions made on your behalf to the Trust. The number of Active Service Units will determine your Benefit Level.

- **How is my monthly Benefit Level calculated if I am a Regular Beneficiary?**

  A Regular Beneficiary's monthly Benefit Level is determined by multiplying the number of Active Service Units (ASUs) he/she has accrued by the Unit Multiplier ("UM") in effect when Contributions cease and the Trust Office receives a claim from the Beneficiary. Effective July 1, 2022, the Unit Multiplier is $0.075. (See Appendix A at the back of this Summary Plan Description.) The Unit Multiplier is a factor determined by the Trustees, with actuarial advice. You may contact the Trust Office to find out the current Unit Multiplier.

[5] The Consolidated Omnibus Budget Reconciliation Act of 1986

Note that: An Employee earns Active Service Units for each hour worked during which his or her Employer makes Contributions to the Trust. The Trust grants one ASU when the Trust Office has received Contributions totaling $5.00. (For each Contribution of $0.05, the Employee earns 1/100th of an ASU.)

(See Appendix B at the back of this Summary Plan Description for examples of Benefit Level calculations.)

Conversion of Leave into ASUs. An Employee may also earn Active Service Units through conversion of sick and/or vacation leave transfers into Active Service Units only if the applicable collective bargaining agreement requires it. Any conversion will be at actuarial costs, which is based on the actual age of the Employee at the date of transfer. To find out the actuarial cost of leave conversion, please refer to Appendix C at the back of this Summary Plan Description, "Leave Conversion Table."

Extra ASUs through Continued Self-Payment (COBRA). If an Employee makes Contributions under his/her COBRA rights (see question directly above), he/she will continue to earn Active Service Units for a maximum of eighteen months.

- **Will the Trust roll over the unused portions of my monthly Benefit Level?**

  Yes, the Trust will roll over any unused portions of your monthly Benefit Level for you to use on future Covered Expenses. For example, if you have a monthly Benefit Level of $100 and you get reimbursed for Covered Expenses of $75 for January of 2023, then you will have $125 available in February. If you have no Covered Expenses in February of 2023, then you will have $225 of unused benefits to spend on Covered Expenses in March (which includes your monthly Benefit Level of $100 for March).

- **Will the Trust carry over Covered Expense amounts that exceed my monthly Benefit Level?**

  Yes, the Trust will carry over Covered Expense amounts that exceed your monthly Benefit Level. However, the Trust will not prepay claims. For example, if you have a monthly Benefit Level of $100 and you submit a claim for Covered Expenses of $300 in January 2023, then you will be reimbursed $100 in January of 2023, $100 in February of 2023, and $100 in March of 2023, i.e., the Trust will not reimburse you $300 in January. (However, if you have new claims in February or March, payment on the new claims will be deferred to April and carried over to subsequent months as necessary.)

- **Is it possible for my monthly Benefit Level to change after I start benefits?**

  Yes, it is possible for your Benefit Level to change, i.e., benefits under the Plan are not vested. The Trustees reserve the right and power to adjust the Unit Multiplier (up or down) or change other Plan terms. Such adjustments may apply to current as well as future Beneficiaries.

- **Why is my monthly Benefit Level different from that of other retirees in my Local and in other Locals?**

  A Regular Beneficiary's monthly Benefit Level is dependent on how long his/her Local has participated in the Trust, the hourly Contribution level negotiated by his/her Local, and how many Active Service Units he/she has earned. Thus, the individual monthly Benefit Level will differ among Plan participants, even within the same Local.

PART 4
EMPLOYEE ACCOUNT BENEFITS

- **What are Employee Account benefits?**

  Employee Account benefits are benefit payments to a Limited Beneficiary for reimbursement of Covered Expenses in any amount, up to the balance of his/her Employee Account. Claims will generally be reimbursed until the Employee Account balance falls to zero, subject to the Trust's claims procedures. See Plan Section 3.5(c) for details.

- **How do I become a Limited Beneficiary, eligible for Employee Account benefits?**

  An Employee will become a Limited Beneficiary eligible for Employee Account in three circumstances:

  1. The Employee has **less than five years of Active Service** credits and is no longer working in a participating hospital or institution; or

  2. The Employee has an accrued leave transfer to the Trust, pursuant to a collective bargaining agreement; or

  3. The Employee has **five or more years of Active Service,** but less than $5000 of Contributions were made to the Trust on his/her behalf, the Employee is no longer working for a participating hospital or institution, and the Employee elected an Employee Account benefit instead of a monthly benefit; or

  In the first two circumstances above, the Employee automatically becomes a Limited Beneficiary, and has an Employee Account. In the third circumstance (more than five years of Active Service), the Employee can choose whether to become a Regular Beneficiary eligible for regular monthly benefits for life, or a Limited Beneficiary, eligible to spend down his or her Employee Account quickly. In the second circumstance, the Employee may become both a Regular Beneficiary and a Limited Beneficiary. See discussion below of the advantages and disadvantages of each benefit. **(The Employee Account is a recordkeeping account kept by the Trust Office, not an actual separate bank account.)**

- **What are the advantages and disadvantages of electing Employee Account benefits, in place of monthly benefits?**

  Advantages and Disadvantage of Employee Account Benefit.

  The **advantage** of the Employee Account is that there is no monthly limit on benefit payments and so it is useful to pay for larger medical expenses all at once. You can spend your Employee Account as quickly as you like (so long as you have Covered Expenses to reimburse). Your Surviving Spouse and Children can also receive benefits from the Employee Account until the Employee Account balance reaches zero.

  The **disadvantage** of the Employee Account is that it is likely to run out fairly quickly, and perhaps many years before you (or your spouse) die. We have found that participants with 6 to 9 years of Active Service would have an Employee Account balance somewhere between $2000-$3500 (depending on the Contribution rate in their collective bargaining agreement).

  Advantages and Disadvantage of the Lifetime Monthly Reimbursement Benefit.

  The **advantage** of the regular monthly benefit to "Regular Beneficiaries" is that it is designed to last for your lifetime, and the lifetime of your spouse.[6] There is a Surviving Spouse benefit for the spouse's lifetime at 50% of your Benefit Level – these survivor benefits start when you would have reached age 55 – or immediately upon death if you were over age 55.

  The **disadvantage** of the monthly benefit for Employees who were not in the Plan that long is that it may be a relatively small monthly benefit, and not worth your time and effort to make monthly claims for reimbursement. You can call the Trust Office at the phone number below to find out your current monthly Benefit Level. (See Part 8 below for contact information.) Employees with less than $5,000 in total Contributions can choose an Employee Account benefit instead of a monthly benefit. See information below.

- **If qualified, how do I elect Employee Account benefits?**

  Retirees who are qualified to elect the Employee Account option (those with $5,000 or less in Contributions to the Plan) can do so by signing and submitting the Employee Account Election Form to the Trust Office. Contact the Trust Office by phone or email to receive an Election Form. (See Part 8 for contact information.) The Election Form must be received by the Trust Office prior to payment of any benefit claims to you; so make sure the Trust Office has received your Election Form prior to submitting any claims.

[6] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify, limit, or terminate benefits as necessary to preserve the financial soundness of the Plan. The monthly benefit payments are not guaranteed at a particular level; the Board of Trustees reserves the right to adjust the Unit Multiplier for calculating monthly Benefit Levels up or down at any time for some or all current and/or future Beneficiaries.

Effective Date. The election for Employee Account benefits is available to participants who retire on or after April 1, 2019, and have not yet received benefit payments from the Plan.

Please note: The election for Employee Account benefits, instead of monthly benefits, is an irrevocable election. Upon the Trust Office's receipt of your signed Election Form, you will be considered a "Limited Beneficiary" under the Plan, and the Trust Office will set up your Employee Account.

- **When may a Limited Beneficiary begin receiving Employee Account benefits?**

  A Limited Beneficiary may begin receiving his/her Employee Account benefits after separating from all employment (including per diem employment) with his/her Participating Employer and meeting one of the following requirements:

  1. He or she is between ages 40-55 and 24 months have passed since the Plan received Contributions on his or her behalf; or

  2. He or she has attained age 55; or

  3. The Social Security Administration has determined that he or she is disabled.

- **How is the balance of my Employee Account calculated?**

  The balance of an Employee Account will be determined, generally, by adding:

  1. The total amount of hourly payroll employee Contributions made on behalf of an Employee who does not meet the minimum Active Service requirements of five years to qualify for monthly benefits;

  2. The amount of employer Contributions made on behalf of an Employee who does not meet the minimum Active Service requirements of five years but: (i) was 50 years old or older when Contributions first started to the Trust, or (ii) the Employee could not meet the minimum Active Service requirements because of a disability as determined by the Social Security Administration;

  3. Amounts of sick and/or vacation leave[7] transferred to the Trust, pursuant to your collective bargaining agreement;

[7] Important Note: The Trust only accepts sick and/or vacation leave that is transferred to the Trust as a mandatory (non-elective) transfer under a collective bargaining agreement or some other written agreement. The IRS has ruled that sick and/or vacation leave that is mandatorily transferred into a retiree health account is exempt from income tax under IRS Revenue Ruling 75-539 and subsequent private letter rulings. Please consult with your tax preparer if you have questions regarding this matter. If you would like a copy of Revenue Rule 75-539 to provide to your tax preparer, please contact the Trust Office.

4. For a Regular Beneficiary who elects to become a Limited Beneficiary with an Employee Account, the total amount of all (employee and employer) hourly payroll Contributions made on behalf of the Employee, adjusted for the actual past investment returns earned (or lost) during the period that the Plan received Contributions on the Employee (including COBRA Contributions), until the date that the Trust Office received an Employee Account Election Form from the Beneficiary. No investment earnings or losses will accrue after the Employee submits the Employee Account Election Form.

And subtracting:

5. Any benefit payments; and
6. An Account Administration Fee as determined by the Board of Trustees (See Plan Sections 2.1(c)(5) and 3.5(e).

There will be no investment earnings or losses, or investment expense adjustments to the Employee Accounts, except as provided above during establishment of an Employee Account for a Regular Beneficiary who elects to become a Limited Beneficiary.

PART 5
LOSS, DENIAL, OR DELAY OF BENEFITS

- **What circumstances may result in ineligibility or denial of benefits?**

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include failure by the Employee or employer to make required Contributions, failure to properly submit Covered Expense documentation, failure to meet the eligibility requirements, death of the Beneficiary, or termination of the Plan.

The following events will result in automatic termination of benefits:

1. A Regular Beneficiary's benefits under this Plan will terminate upon his/her death.

2. A Limited Beneficiary's benefits under this Plan will terminate when the Employee Account balance reaches zero.

3. An Employee's benefits under this Plan will be suspended upon return to employment (including per diem employment) with a Participating Employer; provided, however, that benefit payments will resume after the Employee ceases all employment with the Participating Employer.
4. A Surviving Spouse's benefits under this Plan will terminate upon his/her death, or, for the Surviving Spouse of a Limited Beneficiary, when the Employee Account balance reaches zero.

5. A Surviving Child(ren)'s benefits under this Plan will terminate upon the loss of Child(ren) status, or upon his/her death, or for the Surviving Child(ren) of a Limited Beneficiary, when the Employee Account balance reaches zero.

- **Can my benefits be reduced by Plan amendment or termination?**

  Yes. The Trustees reserve the right to modify benefit coverage and Benefit Levels, or to terminate the Plan, and such changes may apply to current and/or future Beneficiaries. In the event the Plan is terminated, any Plan assets that remain after payment of expenses associated with termination will be allocated and distributed to the Beneficiaries in accordance with Section 501(c)(9) of the Internal Revenue Code. See Plan Sections 3.4 and 3.5 for details.

- **When do I need to contact the Trust Office to update my personal information?**

  You should contact the Trust Office with any changes you experience that might affect your benefits or rights from the Trust, including but not limited to, the following:

  1. Change in your mailing address;

  2. Change in your employment status (e.g., retirement, lay-off, or reduction in hours);

  3. Change in your spouse (e.g., divorce or marriage);

  4. Death of a Beneficiary; and/or

  5. New children (e.g., by birth or adoption).

  It is important for the Trust Office to have an up-to-date record of any personal information that might affect your benefits and rights under the Plan. Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan.

PART 6
SURVIVOR BENEFITS

- **What benefits will my spouse and children receive if I die?**

  Regular Beneficiaries Receiving Monthly Benefits. A Surviving Spouse of a Regular Beneficiary, with or without Children, is eligible for monthly benefits equal to 50% of the Benefit Level of the deceased Regular Beneficiary. If there is no Surviving Spouse, the monthly Benefit Level for Surviving Children of a Regular Beneficiary will be 50% of the Benefit Level for the deceased (to be divided among Children based upon claims made in each month). A Surviving Spouse's or Surviving Child(ren)'s if there is no Surviving Spouse) monthly benefit will include any of the Regular Beneficiary's accumulated and unused

benefits. Note that a Surviving Child's monthly benefits under this Plan will terminate upon the loss of "Child" status, as defined in the Plan.

Employee Account Benefits. The Surviving Spouse of a Limited Beneficiary with an Employee Account with a positive balance is entitled to reimbursement benefits in an amount equal to the balance of the deceased Limited Beneficiary's Employee Account. If there is no Surviving Spouse, then the Surviving Child(ren) of the deceased Limited Beneficiary is entitled to the Employee Account benefits.

PART 7
BENEFIT CLAIM AND APPEAL PROCEDURES; LAWSUITS

- **How do I submit my claims for benefits?**

To present a claim for benefits under this Plan, you must submit a written claim on an approved claim form within three months after the end of the Plan year in which the Covered Expense was incurred.[8] The Plan year ends on December 31. (However, the Trust Office may waive the deadline for good cause shown, according to guidelines set by the Trustees.) Beneficiaries may contact the Trust Office to request an approved claim form.

Claims must be sent to the Trust Office by mail, email, fax, or web portal:

Health Professionals and Allied Employees,
AFT/AFL-CIO Retiree Medical Trust
c/o Zenith American Solutions, Inc.
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534

Fax: (201) 947-9192
HpaermtClaims@Zenith-American.com

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

(a) The date that the medical services or supplies were provided or the dates of coverage for insurance premiums.

(b) A description of the medical services, supplies, or premiums.

[8] Note: if you have elected to use the PBS Debit Card, all claims will be processed by PBS. You may use the PBS website for information about your balance and claim history. Please set up your account at www.PBSCard.com in order to view your account, submit online claims, and learn how to use the debit card. If you have any questions

about registering for the PBS Debit Card, please contact the Trust Office at the contact information included above for additional details.

(c) 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:

(1) Canceled check drawn to the name of the medical service, supplies, or insurance provider;

(2) Copy of confirmation of electronic payment to the medical service, supplies, or insurance provider, including a pension statement showing a deduction for premium payments.

(3) Receipt for payment from the medical service, supplies, or insurance provider.

For reimbursement of medical expense claims that are not recurring monthly premiums for health, dental, vision, or long-term care insurance, you must submit the above documentation for every claim. The Trust Office will not pay your benefit payment until proper documentation of prior payment of Covered Expenses is received. You can send your claims monthly or batch them and send less frequently, as long as you comply with the claims deadline.

For reimbursement of claims for recurring monthly premiums for health, dental, vision, or long-term care insurance, you must submit, at least annually, the Trust's claim form and the third-party insurance documentation listed above in bullet points (a) – (c) of this Part 7. In addition to submitting these documents at least annually, to receive reimbursement of recurring monthly insurance premiums that are not Medicare premiums, you must submit proof that a Beneficiary has paid the same amount for premiums each month. Examples of proof of payment are: cancelled check to insurance carrier, insurance carrier statement showing premium paid, pension statement showing deduction of premium, bank statement or credit card statement showing premium payment amount. You can send proof of your payment monthly or you can batch proof of payment documentation less frequently, as long as you comply with the annual claims deadline. However, you will only be reimbursed for months for which the Trust Office has received your proof of payment. If your premium amount changes before the next annual verification request from the Trust Office (most likely due to Medicare eligibility), you must submit a new claim form and third-party insurance documentation of your premiums.

For reimbursement of recurring monthly Medicare premiums, you must submit annually, and upon request, the Trust's claim form and your Social Security Administration statement showing the amounts deducted from your social security payments, or otherwise paid by you for Medicare premiums.

You may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Details for claim submission are set forth in Plan Section 3.6.

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

  To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, you must submit a written request to the Trust Office within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. The Board of Trustees will hold a hearing on the appeal, and you will be entitled to present your position and any evidence in support of your appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision.

  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.

  Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial. See Plan Sections 4.1-4.4.

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

  Yes, there is a limitation period for filing a lawsuit against the Trust for benefit payments, etc. You have the right to bring action in federal court pursuant to ERISA Section 502(a) no later than one year after the exhaustion of administration remedies (i.e., the appeal process above), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint.

PART 8
ADMINISTRATION AND THE BOARD OF TRUSTEES

- **Who is the Plan Administrator?**

  The fiduciary of the Plan (known under federal law as the "Plan Administrator") is the Board of Trustees of the Health Professional and Allied Employees, AFT/AFL-CIO Retiree Medical Trust. The Board has retained the services of a contract administrator (the "Trust Office") to assist in recordkeeping, claim payments, etc. You may contact the Board in care of the Trust Office.

- **What are the names and addresses of the Trustees?**

  Mike Slott, Chairman
  HPAE
  4 Aubrey Road
  Montclair, NJ 07043
  Phone: (973) 979-0703

  Louis Lessig, Esq.
  Brown & Connery, LLP
  P.O. Box 539
  360 Haddon Avenue
  Westmont, NJ 08108

Fax: (201) 262-4335

Phone: (856) 854-8900
Fax: (856) 858-4967

Alice Howarth
c/o HPAE
11 E. 25th Street
Long Beach Township, NJ 08008
Phone: (609) 276-6133

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

You can contact the Trust Office at:

Health Professionals and Allied Employees,
AFT/AFL-CIO Retiree Medical Trust
c/o Zenith American Solutions, Inc.
HPAE Retiree Medical Trust
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534

Phone: (201) 947-8000
Fax: (201) 947-9192
HpaermtClaims@Zenith-American.com

PART 9
GENERAL INFORMATION ABOUT THE PLAN AND TRUST

- **What are the official name and identification numbers of the Plan and Trust?**

This Plan is known as the "Medical Expense Reimbursement Plan of the Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust," restated and effective March 1, 2023 and as amended hereafter (the "Plan"). This Plan is governed by the "Trust Agreement Governing the Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust," effective July 1, 2006 and as amended from time to time thereafter ("Trust Agreement"). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 68-6254830.

The Plan number is 501.

- **What is the Plan Year, and why is it important?**

The Plan year runs from January 1 – December 31. It is important because you must submit

claims within three months of the end of the Plan year, unless the Trust Office has waived the deadline.

- **What is the name, address and telephone number of the employee organization that established this Plan?**

  The Plan was established by the Health Professionals and Allied Employees, AFT/AFL-CIO ("HPAE") which is a labor organization representing healthcare professionals. The name, address and telephone number of HPAE is as follows:

  Health Professionals and Allied Employees, AFT/AFL-CIO
  110 Kinderkamack Road
  Emerson, NJ 07630
  Phone: (201) 262-5005

- **What type of plan is the Medical Expense Reimbursement Plan?**

  The Plan is a welfare benefit plan providing health insurance premium and medical expense reimbursement benefits to retirees.

PART 10
PARTICIPATING LOCALS & CONTRIBUTIONS

- **Are there bargaining agreements that address Contributions to this Plan and Trust?**

  Yes, the Plan is maintained pursuant to various Collective Bargaining Agreements ("CBAs"), and applicable successor agreements, between HPAE and Participating Employers. Beneficiaries may obtain copies of the CBAs upon written request to the Trust Office. The Trustees may impose a reasonable charge to cover the cost of copies.

- **What is the source of Contributions to the Trust, and how are the assets protected? What are the tax benefits of the Trust?**

  Contributions to this Plan must be non-elective, that is, required by a CBA or Special Agreement. They may be employer and/or employee Contributions. However, under certain limited circumstances, Beneficiaries may make COBRA self-payment Contributions.

  Contributions are received and held in trust and are invested by the Trust with the assistance of a professional investment manager, using investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 ("ERISA").

  This Trust has three tax advantages:

  1) Contributions are not taxed. Your employee Contributions to the Trust are pre-tax. If that money had gone into salary, it would have been taxable.

2) Earnings are not taxed. After the Contributions are made to the Trust, they become plan assets and are invested by the Trust's professional investment manager. The earnings on these investments are not taxed. This means that the "Unit Multiplier," which determines your monthly Benefit Level, can be higher. (See Part 3 hereof for a discussion of the Unit Multiplier.)

3) Benefit payments are not taxed. Finally, the benefit payments you will receive from this Trust are not taxable income. When you get reimbursed from the Trust as a retiree for Covered Expenses, you will not have to report this money as taxable income. Due to this tax treatment, you cannot deduct Covered Expenses reimbursed by this Plan on your personal tax return.

PART 11
LEGAL RIGHTS

- **What is the name and address of the agent for service of process?**

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Trustee or the Trust Office.

- **What are my legal rights under applicable federal statutes?**

A. Family Medical Leave Act

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

- ❖ For the birth and care of a newborn child of the Employee;
- ❖ Placement with the Employee of a child for adoption or foster care;
- ❖ To care for an immediate family member (spouse, child, or parent) with a serious health condition; and
- ❖ To take medical leave when the Employee is unable to work because of a serious health condition.

There are more reasons. Contact the Trust Office for details.

B. Uniformed Services Employment and Reemployment Rights Act (i.e., Veterans rights under USERRA)

If your contributions to this Plan cease due to a leave of absence for active duty military service, you have the right under USERRA to self-pay contributions for up to 24 months of that period of leave. If you would like to take advantage of your rights under USERRA, contact the Trust Office for details. Regardless of whether or not you elect to self-pay contributions under USERRA, the Plan will preserve all Active Service that you earned prior to your period of leave and that Active Service will be added to any future Active Service that you earn after you return to employment with a Participating Employer following your leave of absence.

C. Consolidated Omnibus Budget Reconciliation Act (COBRA)

For a description of your rights under COBRA, please see the General COBRA Notice, provided at the end of this Summary Plan Description. Also, if you would like to request a copy of the General COBRA Notice, please contact the Trust Office.

The Employee or a family member, who is a Qualified Beneficiary, has the responsibility to provide written notice, within the time limits described in Section 4 of the General COBRA Notice, 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;
iv) Determination of Disability by the Social Security Administration; or
v) Change of Disability Status.

The period of time for providing notice to the Trust Office of a Qualifying Event, is from the date of the Qualifying Event to sixty (60) days after the latest of:

i) Qualifying Event. The date that the Qualifying Event occurs;
ii) Contributions to the Trust Cease. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or
iii) The Date you Receive Notice. The date that you are informed through the General COBRA Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 of the General COBRA Notice).

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

If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions. The contact information for the Trust Office is as follows:

Health Professionals and Allied Employees,
AFT/AFL-CIO Retiree Medical Trust
C/o Zenith-American Solutions
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534
Fax: (201) 947-9192

Your notice of the Qualifying Event should include:

i) Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;
ii) Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and
iii) Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

D. Divorce: Qualified Domestic Relations Order (QDRO)

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

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

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

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

Beneficiaries can obtain from the Trust Office, without charge, a copy of the procedures governing the determination of whether a Domestic Relations Order is qualified. The Trust may assess a fee on the Employee and/or Beneficiary for the review process. (The same applies for Medical Child Support Orders.)

E. Qualified Medical Child Support Order (QMCSO)

Beneficiaries can obtain, without charge, a copy of procedures governing the determination of a QMCSO by contacting the Trust Office. Beneficiaries can also obtain review of a proposed QMCSO from the Trust Office.

F. Important Information: Statement of Legal Rights

- Rights of Plan Participants. Beneficiaries of the Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust are entitled to certain rights and protections under the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

  - Examine, without charge, all documents governing this Plan, including CBAs, insurance contracts and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, at the Plan Administrator's office and at other specified locations, such as worksites and union halls. The annual report is also available at the Public Disclosure Room of the Employee Benefits Security Administration.

  - Obtain copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a

copy of the latest annual report, and an updated Summary Plan Description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (SAR). The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.

- Continue Contributions to the Plan by self-payment under COBRA, if there is a cessation of Contributions to the Plan as a result of a COBRA qualifying event. See the General COBRA Notice and Plan Sections 2.2(b) and 2.2(c) for rules governing your COBRA continuation coverage rights.

❖ Prudent Actions by Plan Fiduciaries. ERISA imposes certain obligations upon the persons who are responsible for the operation of this employee welfare benefit plan. The persons who operate your Plan and Trust are legal "fiduciaries." Fiduciaries must act solely in the interest of the Plan Beneficiaries, and must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to compensate the Trust for any losses they cause to the Trust. No one, including an employer, may fire or otherwise discriminate against members to prevent them from obtaining a welfare benefit or from exercising their rights under ERISA.

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

Under ERISA, you can take steps to enforce these rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suite in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance form the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

- Assistance with Your Questions. If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U,.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, at (866) 444-EBSA (3272).

- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health benefit plans to protect the privacy of "protected health information." In the course of providing benefit to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. A copy of the HIPAA Privacy Notice is attached to this SPD. If you would like more details about your privacy rights or a copy of the Privacy Notice, please contact the Trust Office.

APPENDIX A
UNIT MULTIPLIER

Operative Period**	Unit Multiplier*
August 1, 2014 – June 30, 2022	$0.070
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 (effective July 1, 2022)

Example #1 – 6 years in Trust: 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

Example #2 – 12 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 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.

Section 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 35	3.74	267
Age 36	3.97	252
Age 37	4.21	238
Age 38	4.46	224

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 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

COBRA GENERAL NOTICE
of the
HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO
RETIREE MEDICAL TRUST

<< IMPORTANT COBRA INFORMATION >>

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

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

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contribution (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,[9] rather than health benefits insurance coverage for former employees of any age. That is, this Plan is 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 Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust (hereafter the "Trust"), which provides reimbursement towards certain medical expenses, as defined in the Plan, after retirement. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[10]

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

[9] 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.

[10] Public Law 99-272, Title X

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

THIS NOTICE DOES NOT FULLY DESCRIBE THE CONTINUATION COVERAGE OR OTHER RIGHTS UNDER THE PLAN. MORE COMPLETE INFORMATION REGARDING SUCH RIGHTS IS AVAILABLE FROM THE TRUST OFFICE AND IN THE SUMMARY PLAN DESCRIPTION, AND YOU MAY CONTACT THE TRUST OFFICE AT CONTACT INFORMATION IN SECTION 5 HEREOF FOR SUCH INFORMATION.

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

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Trust by self-payment, when contributions to the Trust would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying Event, the Plan must offer each person who is a "Qualified Beneficiary" the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a collective bargaining agreement or special agreement. By offering a Qualified Beneficiary this right, generally, the Plan is offering that individual the ability to increase their benefits from the Plan in one of three ways:

i) The ability to meet the eligibility requirement to become a Regular Beneficiary and receive a lifetime[11] monthly reimbursement benefit from the Plan after retirement, which he/she may not otherwise have been able to meet (see Section 2(B) below);

ii) To augment their monthly post-retirement benefit, if the person had already met the eligibility requirements to become a Regular Beneficiary; and/or

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

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

B. Plan Eligibility Requirements. To be eligible to receive the monthly lifetime medical expense reimbursement benefits after retirement as a Regular Beneficiary (subject to Plan rules), this Plan requires that the Employee earn five (5) years of Active Service as

[11] 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 or terminate benefits as necessary to preserve the financial soundness of the Plan.

defined in Section 2.2 of the Plan. Therefore, making COBRA self-payments could enable you to meet the Active Service requirement and become eligible for monthly benefits, 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 amount of years of your contributions, you may be able to increase your monthly Benefit Level if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in Section 6 below.

Finally, if you cannot become eligible for the monthly lifetime benefits, your contributions are recorded separately in an Employee Account, which you can access upon separation from employment and reaching age 55, or reaching age 40 on the condition that the Plan has not received contributions on your behalf for over 24 months, or receiving a disability determination by the Social Security Administration. (Note that under the circumstance that you are not able to become eligible for monthly benefits with your COBRA contributions, you might be making COBRA contributions to your Employee Account and then withdrawing those same funds for reimbursement of medical expenses.)

We urge you to consult with your personal tax advisor on this matter. Note that contributions will be made with after-tax dollars.

C. Widowed spouses and Children. Widowed spouses and Children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in Section 5 below for details.

D. Consequence of Non-Election. If you do not choose to continue contributing to this Plan and have not yet earned five years of Active Service, you will not qualify for monthly benefits as a Regular Beneficiary. Instead, you will be eligible to receive benefits limited to the balance credited to your Employee Account in accordance with Section 3.5 of the Plan.

3. Qualifying Events and Qualified Beneficiaries.

A. An Employee as a Qualified Beneficiary. If you are an Employee**,** you will become a Qualified Beneficiary and have the right to self-pay contributions if contributions to the Trust on your behalf cease due to any of the following "Qualifying Events:"

i) Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or

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

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

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

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

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

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

iv) Divorce. If the Employee and spouse divorce (including legal separation) 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.

In order to preserve your right to make COBRA contributions, if the Qualifying Event is a divorce, you must notify the Trust Office of your divorce, in writing, within 60 days of the date that your divorce becomes final. If you do not timely notify the Trust Office of your divorce, you will surrender your right to make COBRA contributions.

*Note: Only one member of a family may make self-payment contributions in this type of health plan. If there are multiple Qualified Beneficiaries, for example a former employee and a spouse, you should confer together and decide whether electing to make COBRA self-pay contributions makes sense in your case, and which of you will make the election. It is important to note that due to the nature of this type of Plan, you do not each have independent rights to elect self-payment. This means that only one Qualified Beneficiary can self-pay.

C. A Child as a Qualified Beneficiary. If you are a Child of an Employee covered by this Plan, and neither of your parents elects to self-pay contributions to this Plan under

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

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

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

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

In order to preserve your right to make COBRA contributions, if the Qualifying Event is the loss of Child status under the Plan, you must notify the Trust Office of your 26th birthday and loss of benefits, in writing, within 60 days after your 26th birthday. If you do not timely notify the Trust Office of your birthday and loss of benefits, you will surrender your right to make COBRA contributions.

*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 has the obligation to notify the Plan Administrator of the Qualifying Event. However, we urge the employee to also give notice to the Plan, in case the employer fails to do so.

B. Qualified Beneficiary's Notification Responsibility. Under COBRA, the Employee or a family member has the responsibility to provide written notice, within the time limits described in Section 4(C) below, to the Trust Office of the occurrence of any of the following Qualifying Events:

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 eighteen (18) months (or twenty-nine (29) months in the case of a disability, as described in Section 6 below);

iv) A determination by the Social Security Administration that a Qualified Beneficiary has become disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or

v) A determination by the Social Security Administration that a Qualified Beneficiary who was determined as disabled is no longer disabled.

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

i) Qualifying Events Other Than Disability, Divorce, Loss of Child Status. The period of time for providing notice to the Trust Office of a Qualifying Event, is from the date of the Qualifying Event to **sixty (60) days after** the latest of:

a) *Qualifying Event.* The date that the Qualifying Event occurs;

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 Divorce. You must notify the Trust Office of your divorce, in writing, within the latest of the following time periods:

a) You must notify the Trust Office of your divorce, in writing, within the latest of the following time periods; or

b) Within 60 days of 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).

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

iii) Qualifying Event of Loss of Child Status. You must notify the Trust Office by 60 days after the latest of the following time periods, provided that you incur a loss of eligibility for current benefits:

a) Your 26th birthday; or

b) 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).

If you do not timely notify the Trust Office of your birthday and loss of benefits, you surrender your right to make COBRA contributions.

iv) Notice re Qualifying Event of Disability. If the Qualifying Event is a determination that a beneficiary is disabled, the Employee or other Qualified Beneficiary must notify the Trust Office no later than sixty (60) days after the latest of the following events (but no later than the end of the first eighteen (18) months of self-payment contributions):

a) *Determination by Social Security Administration.* The date of the disability determination by the Social Security Administration;

b) *Disability.* The date that the disability occurs;

c) C*ontributions to the Trust Cease.* The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

iii) Change of Disability Status. The period of time for providing notice to the Trust Office of a change in disability is thirty (30) days after the latest of:

a) *Determination by Social Security Administration.* The date the Social Security Administration determines that you are no longer disabled; or

b) *Notice of Responsibility and Procedure.* The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice to the Trust Office (see Section 5 below)

5. Procedures for Notifying Plan of Qualifying Event. Subject to the time limits in Section 4(C) above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s),

described in Section 4(B) above, to the Trust Office by either first class mail or facsimile (fax). If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions. The contact information for the Trust Office is as follows:

Health Professionals and Allied Employees,
AFT/AFL-CIO Retiree Medical Trust
c/o Zenith-American Solutions
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534
Fax: (201) 947-9192

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 right to elect to continue your contributions to the Trust for the right to receive future benefits.

6. **Maximum Length of COBRA Payments.** Once you have elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within 45 days of your election. Subsequent periodic payments must be made on a monthly basis and are due on the first of each month, but no later than 30 days following the first of the month. **You will not receive monthly reminders that payment is due.**

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment of contributions to the Trust.

i) 18 month period. When the Qualifying Event is a termination of employment or reduction in hours of employment, the law requires that you be given the opportunity to self-pay contributions for eighteen (18) months.

ii) 36 month period. When the Qualifying Event is death of the covered employee, divorce, or loss of child status, the COBRA law requires that you be given the opportunity to continue to make contributions to the Trust by self-payment for thirty-six (36) months (three years).

B. Second Qualifying Event Extension (18 month extension of the initial 18 month period). If a second Qualifying Event, other than termination of employment, occurs during the eighteen (18) month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to eighteen (18) months of self-payment contributions, for a maximum of thirty-six (36) months. See Sections 4(B)-(C) and 5 relating to notification requirements and procedure in the case of a second Qualifying Event.

C. Disability Extension (11 month extension of the initial 18 month period). If a Qualified Beneficiary under the Plan is determined by the Social Security Administration to be disabled, the Plan beneficiaries may be eligible to self-pay for an additional eleven (11) months, for a total of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of the COBRA self-payment contributions and must last at least until the end of the 18-month period of self-payment contributions. See Sections 4(B)-(C) and 5 relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional eleven (11) months may be approximately 50% higher than the amount of the first eighteen (18) months, if the self-payment contributions include a disabled beneficiary and the extension of period for self-payment contributions would not be available in the absence of a disability.

7. **Termination of COBRA Payments.** The COBRA law provides that your right to continue COBRA payments may be terminated prior to the full self-payment period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

A. The Trust no longer maintains the Plan; or

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

C. The monthly self-pay contribution to the Trust under COBRA is not paid timely; or

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

You do not have to show that you are insurable to choose continued participation.

8. **Refund of Contributions Erroneously Paid.** Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Plan Administrator and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to

self-pay contributions. Any Active Service granted based on an erroneous contribution will be rescinded.

9. **Questions about COBRA.** If you have any questions about the Plan or your COBRA continuation self-payment rights, you should contact the Trust Office at the address and/or phone number appearing below.

Health Professionals and Allied Employees,
AFT/AFL-CIO Retiree Medical Trust
HPAE Retiree Medical Trust
2 Gateway Center
603 Stanwix St., Suite 1500
Pittsburgh, PA 15222-1534
Phone: (201) 947-8000
Fax: (201) 947-9192

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.