

SUMMARY PLAN DESCRIPTION

of the

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN (IAFF MERP)

of the

**WASHINGTON STATE COUNCIL
OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST**

*Based on Plan restated effective August 1, 2023
Distributed November 2023*

Including COBRA General Notice and
HIPAA Notice of Privacy Practices

Dr. 10/24/23

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN

November 2023

Dear Participants:

The IAFF Medical Expense Reimbursement Plan (“IAFF MERP” or the “Plan”) was established to provide an important piece of financial support during your retirement. Your participation in IAFF MERP means you are building a fund to assist with medical costs that you will incur after you retire. Your Local has negotiated Contributions to the Trust in your Collective Bargaining Agreement.

The IAFF MERP is highly tax-favored. The contributions are pre-tax dollars; Plan earnings are not taxable; and when you begin receiving benefits in the future, they will not be taxed (unless you elect to receive a reimbursement for insurance premiums paid with pre-tax income).

The IAFF MERP is administered by a Board of Trustees, who are fellow fire fighters selected by the membership of participating Locals. We are very pleased to provide you this “Summary Plan Description” that provides general information about the operation of IAFF MERP in a Question-and-Answer format and describes the rights and protections to which you are entitled under federal law.

The Board of Trustees are committed to the successful operation of this Plan, in hopes of helping fire fighters and their families decrease the burden of retiree healthcare costs.

Please contact the Trust Office or one of the Trustees (contact info in this Summary Plan Description) if you have any questions or comments on the Plan.

Fraternally,
Greg Markley, Chairman
IAFF MERP Board of Trustees

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

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NOTE: References in this Summary Plan Description to “Plan Sections” refer to the formal “IAFF Medical Expense Reimbursement Plan” of the Washington State Council of Fire Fighters Employee Benefit Trust, restated effective August 1, 2023. You may review that document by going online to <https://iaff-merp.simon365.com>.

You may also obtain a hard copy of the formal Plan document by contacting the Trust Office at:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743
Fax: (866) 676-1530
Email: iaff-merp@vimly.com

HIGHLIGHTS OF IAFF MERP

- Eligibility. Generally, Employees need five (5) years in IAFF MERP to achieve eligibility for monthly benefits from the Trust. However, for Employees who are within five years of retirement when their Local joins the Trust, there is a limited benefit – See Q&A 4 below.
- Benefits. Your benefits from this Trust come in the form of monthly reimbursement for certain medical costs, which are called “Covered Expenses,”¹ incurred after you retire, limited to the amount of your Monthly Benefit Level, Accumulated Benefit, and/or Individual Account. The “Benefit Calculator” section on the Trust’s website at <https://iaff-merp.simon365.com> will give you an approximation of the amount of your Monthly Benefit Level earned thus far, or you can contact the Trust Office for information.
- 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, no later than March 31 of the following year from the date on which you made the payment of the Covered Expense. However, you are encouraged to submit your claims throughout the Plan year.
- Change of Address or Family Composition. If you move or have a change in mailing address, it is your responsibility to update the mailing address on file with the Trust Office. It is also your responsibility to update the information on file with the Trust Office if you have a change in family composition, e.g., marriage, divorce, or birth of a child. Failure to notify the Trust Office may result in loss or delay of benefit payments.
- Trust Office (Administrative agent of Trust). The Trust Office is a valuable resource and provides important services to the Trust. For example, to find out your Monthly Benefit Level, apply for benefits, submit any benefit claims, request a copy of the Plan or notify the Trust of a change in address, you will need to contact the Trust Office. The Trust Office may be contacted at the following:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743 or Fax: (866) 676-1530
Email: iaff-merp@vimly.com
Website: <https://iaff-merp.simon365.com>

¹ Capitalized terms contained herein are defined in the formal Plan document, and many are described in this Summary Plan Description (“SPD”).

NOTE: The Questions & Answers in this Summary Plan Description have been designed to provide you with key information about the IAFF MERP but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the “IAFF Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust,” restated effective August 1, 2023, and as amended from time to time thereafter. If there is a conflict between what is contained in the Plan, and what is contained in the Summary Plan Description or any other descriptions, the terms of the Plan will prevail.

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Summary Plan Description

1. Who can participate in IAFF MERP (or the “Plan”)?

Eligibility in IAFF MERP (or the “Plan”) is generally available to all Employees who are represented by a bargaining unit of a member Local of the International Association of Fire Fighters that represents fire fighter, fire department and/or paramedic employees and for whom Contributions are made to the Plan as required by the Collective Bargaining Agreement between that Local and the Employee’s Participating Employer.

NOTE re promotions: If you promote out of a participating bargaining unit and there is no agreement between the Trust and your Employer, your contributions may cease. COBRA is not available in this circumstance. Contact the Trust Office for details.

2. Who is eligible for a lifetime Monthly Benefit Level from the Plan?

An Employee described in Q&A 1 becomes an Eligible Retiree entitled to monthly benefits for his or her lifetime² under IAFF MERP after all of the following requirements are met:

- The Employee earns five years of Active Service in the Plan (see Q&A 3).
- Contributions are made to the Plan on behalf of the Employee for all years of Active Service.
- The Employee attains age 53 (except for those who qualify as an Eligible Retiree with Regular Pension Benefits or Disability Pension Benefits prior to age 53).
- The Employee ceases employment with all Participating Employers.

Return to any employment with a Participating Employer after retirement will cause a suspension of all benefit payments for the length of that re-employment. Benefit payments are suspended from the monthly benefit, the Individual Account, and the Accumulated Benefit. Benefit payments from all sources will resume upon separation from all employment with Participating Employers. It is the Eligible Retiree’s responsibility to report re-employment with a Participating Employer to the Trust Office.

² IAFF MERP is currently written to provide benefits until death for Eligible Retirees with the Monthly Benefit Level. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

Age Eligibility Prior to Age 53. An Employee may become an Eligible Retiree under the Plan without attaining the age 53 requirement of Plan Section 2.1(a)(3), if an Employee attains eligibility for Regular Pension Benefits or Disability Pension Benefits prior to age 53, as long as all of the other eligibility requirements listed above are met. These Employees are entitled to start benefit payments immediately after retirement, but at a reduced Monthly Benefit Level, as determined by the Early Retirement Factors Table. The reduction to the Monthly Benefit Level depends upon the age at which the Employee separated from employment, unless the Employee defers benefits to a later date, then the Monthly Benefit Level depends upon the age when the Employee submits the first claim for reimbursement. Monthly Benefit Levels are reduced more for younger Employees because those Employees are expected to receive the monthly benefit for a longer period of time. See the Table in Appendix E at the end of this Summary. An Employee who is eligible for Disability Pension Benefits also has the option to have his/her contributions credited to an Individual Account for reimbursement of Covered Expenses until the balance of the Individual Account is exhausted, instead of a relatively small Monthly Benefit Level based on the Appendix E Table.

Disability Pension Benefits means the Employee has earned eligibility for retirement benefits from the retirement system that the Employee's employer participates in for fire fighter employees due to a work-related disability, as determined by the retirement system. The Employee must submit documentation to the Trust Office of eligibility for and receipt of retirement benefits from the retirement system.

Regular Pension Benefits means the Employee has earned eligibility for retirement benefits from the retirement system that the Employee's employer participates in for fire fighter employees by attaining the normal service and/or age requirements of that retirement system to receive routine benefit payments. The Employee must submit documentation to the Trust Office of eligibility for and receipt of retirement benefits from the retirement system.

An Eligible Retiree who is eligible for lifetime monthly benefit payments is called a "Regular Beneficiary." An Eligible Retiree who is eligible for benefit payments from an Individual Account is called an "Account Beneficiary." See Q&A 7 below regarding Individual Accounts. An Eligible Retiree can be both a Regular Beneficiary and an Account Beneficiary.

3. How do I earn Active Service?

An Employee can earn Active Service and Active Service Units in the following ways:

- Employer Contributions to the Plan from Payroll. Generally, you will receive years of Active Service credit for all periods of full-time employment during which your employer makes Contributions to the Plan on your behalf. You can also earn Active Service credit during a leave of absence, as long as Contributions are made to the Plan on your behalf during that time (either through self-pay COBRA contributions or by your Employer on your behalf pursuant to your CBA). The federal law USERRA also provides for employees on active service military leave to make contributions for up to 24 months of that leave in order to maintain their benefits. If you have questions about Contributions, please contact the Trust Office.
- Conversion of Leave Transfer, Other Lump Sum Transfers, or Individual Account Balance into Active Service and ASUs. The Plan only allows you to earn additional years of Active Service through conversion when conversion is elected at your retirement or separation from employment. When you retire or separate from employment without attaining five years of Active Service, you can use a Lump Sum Transfer received at that time to purchase additional years of Active Service through a COBRA election and/or conversion of your leave transfer (or other Lump Sum Transfer) using the age-related factors on the Lump Sum Transfer Conversion Table. You can also use your Individual Account balance (from prior Lump Sum Transfers) for COBRA payments or conversion, but you cannot use Pooled Contributions received from your former employer's payroll transfers that were credited to the Individual Account balance due to your ineligibility for the monthly benefits. (These Pooled Contributions have already been used to earn Active Service during your active employment.)

Conversion is based on the age of the Employee on the date that the Trust Office receives the conversion election form. Note that the cost of converting a leave transfer or the Individual Account balance into ASUs is higher as the age of the Employee increases due to the decreased time for investment before drawing benefits. Please refer to Appendix C to the Plan, "Leave Conversion Table," attached hereto. The cost of a year of Active Service through leave conversion in Appendix C was actuarially calculated to be equivalent to monthly Contributions during employment.

- Contribution After Termination or Reduction of Employment (COBRA) – Including Retirement. If your Contributions to the Plan cease because your employment is terminated (including for retirement, but not for gross misconduct) or your hours are reduced to less than full-time (e.g., going on leave without contributions), you may continue to earn Active Service and Active Service Units for a maximum of eighteen months, by making monthly self-payments to the Plan

as permitted by the federal law known as COBRA,³ and subject to rules set by the Trustees. An Employee may elect to self-pay COBRA contributions through deduction from Lump Sum Transfers (such as an accrued leave transfer) or from the Individual Account balance, or by sending check payments to the Trust Office. Benefit payments shall not commence until COBRA contributions have stopped. Active Service Units earned through COBRA self-payment cost \$25 per ASU – the same as during active employment, i.e., the Leave Conversion Table does not apply. Please also see Q&A 5 for the use of leave transfers (or Other Lump Sum Transfer), or Individual Account balance to make COBRA Contributions.

COBRA self-payment enables an Employee to reach the minimum requirement of five years of Active Service and/or increase the Employee's Monthly Benefit Level. Active Service Units earned from COBRA payments are added to the Employee's total Active Service Units from other sources and used to calculate the Monthly Benefit Level. Even if the Employee has already attained eligibility for monthly benefits, the Employee can elect to make COBRA contributions to earn additional Active Service Units and a higher Monthly Benefit Level. See attached COBRA General Notice.

4. What happens if I separate from service before I earn five (5) years of Active Service?

An Employee who does not earn five years of Active Service (defined as "Short Service" under Plan Section 3.2(f)) will not be eligible to receive the lifetime⁴ stream of monthly benefit payments. Instead, the total amount of Contributions made on his/her behalf, (without any allocation for investment returns thereon) will be added to the Eligible Retiree's Accumulated Benefit. If an Eligible Retiree with Short Service benefits receives a Lump Sum Transfer, that transfer will be credited to the Eligible Retiree's Individual Account, and the Eligible Retiree will have both an Accumulated Benefit and an Individual Account. This type of Eligible Retiree may submit claims for the reimbursement of Covered Expenses at any time after separation from employment as an Employee in the Plan. There is no monthly limit on the dollar amount of claims that can be reimbursed, as long as all claims are for reimbursement of Covered Expenses and the claimed amount does not exceed the balance of the Accumulated Benefit, plus any Individual Account balance. Benefits cease when the Eligible Retiree has exhausted his or her Accumulated Benefit and/or Individual Account. Please note that any Accumulated Benefit balance or Individual Account balance remaining upon the death of the Eligible Retiree and all of his

³ The Consolidated Omnibus Budget Reconciliation Act of 1986.

⁴ IAFF MERP is currently written to provide benefits until death for Eligible Retirees with the Monthly Benefit Level. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

or her Beneficiaries, or at the time the Surviving Children no longer meet the definition of Child (i.e., under age 26), will forfeit to the Plan.

5. How will mandatory transfer of accrued leave, pursuant to collective bargaining, affect my benefits?

Your Local can negotiate for mandatory transfer of accrued sick and/or vacation leave to the IAFF MERP either annually or at retirement. Individual Employees cannot elect whether to transfer and what percentage of accrued leave to transfer to the IAFF MERP. If transfer of accrued leave (or other employer Lump Sum Transfers) is included in your Local's Collective Bargaining Agreement, then you have the following options related to use of those funds within IAFF MERP:

- Election to Credit Leave Transfer to an Individual Account or Convert Lump Sum Transfer to Active Service Units. Upon receipt of an accrued leave transfer (or other Lump Sum Transfer) for an Employee, the Trust Office will send the Employee a form to elect whether to convert the leave transfer into Active Service Units, or to add the leave transfer (or other Lump Sum Transfer) to the Employee's Individual Account.
- An Employee may elect conversion only upon occurrence of the events listed below:
 - Receipt of a new Lump Sum Transfer;
 - At retirement or separation from employment;
 - During the annual investment selection period while employed and receiving contributions to the Plan, i.e., not after retirement and not during periods of re-hire without contributions.

The rules vary for each event as to the amount of funds you can convert and whether you can receive years of Active Service (for attaining eligibility for a monthly benefit) in addition to Active Service Units (for increasing your Monthly Benefit Level). See below for the details related to each event.

- Conversion election upon receipt of a new Lump Sum Transfer. An Employee may convert the full amount of a Lump Sum Transfer into Active Service Units. An Employee may *not* convert a portion (i.e., less than the full amount) of the Lump Sum Transfer into Active Service Units. The Employee must make this election within the deadline provided in the notice that is received from the Trust Office. The Trust Office will implement the default selection (see below) if you fail to make a timely election on a Lump

Sum Transfer. An active Employee will *not* earn additional years of Active Service toward eligibility for monthly benefits for conversion at this event. The Employee *cannot* convert the current Individual Account balance at this event.

- Conversion election upon retirement/separation from employment. An Eligible Retiree, or Eligible Retiree with Short Service, that receives a Lump Sum Transfer upon retirement/separation from employment, and/or that has an Individual Account balance upon separation from employment, may elect to convert all *or a portion* of such transfer, or all *or a portion* of their Individual Account balance into Active Service Units (i.e., the Eligible Retiree can elect to convert less than the full amount of the Individual Account balance or transfer). The Eligible Retiree must make this election within the deadline provided in the notice that is received from the Trust Office. The Trust Office will implement the default selection (see below) if you fail to make a timely election on a new Lump Sum Transfer that is received upon retirement/separation from employment.

An Eligible Retiree with Short Service cannot use any Individual Account balance resulting from transfer of Pooled Contributions for conversion to Active Service Units. (These Pooled Contributions have already been used to earn Active Service Units during your active employment.)

- Conversion election during annual investment selection period. An active Employee, i.e., receiving Contributions, may elect to convert the full amount of the Individual Account balance during the annual investment selection period. The annual investment selection period typically occurs during April of each year. Any conversions into Active Service Units made during the annual investment selection period must be for the entire amount of the Individual Account balance (i.e., you cannot elect to convert less than the full amount of the Individual Account balance during the annual investment selection period). The Employee will *not* earn additional years of Active Service toward eligibility for monthly benefits for conversion at this event. Retirees cannot convert their Individual Account balance during the annual investment selection period; after the election period has expired following retirement or separation from employment, your conversion rights are expired.

The Trust Office will communicate the deadline to elect conversion in the notice or information packet related to the event.

If the Employee or Eligible Retiree timely submits an election form, the leave transfer (or other Lump Sum Transfer) and/or Individual Account balance is converted to Active Service Units based upon the current Lump Sum Transfer Conversion Table in effect on the date that the Trust Office receives the conversion election form. Elections are irrevocable after the Trust Office has received your completed, signed election form.

- Use of Leave Transfer (or Other Lump Sum Transfer), or Individual Account Balance to Make COBRA Contributions. If the Employee has experienced a COBRA qualifying event, such as termination or retirement from employment or reduced hours, then the Employee also has the option to use some or all of the accrued leave transfer (or other Lump Sum Transfer) and/or Individual Account balance (except for any Individual Account balance resulting from transfer of Pooled Contributions) to make COBRA contributions to purchase additional ASUs at \$25 per ASU. The Employee can elect this option by selecting to pay the COBRA contributions with leave transfer or Individual Account balance on the COBRA Election Form received from the Trust Office. The COBRA Election Form must be mailed (postmarked) or delivered to the Trust Office within 60 days of the date on the COBRA Election Form. After the COBRA contributions from leave transfer (or other Lump Sum Transfer) are completed, any remaining amount of leave transfer (or other Lump Sum Transfer) is subject to the election between credit to the Individual Account or conversion to ASUs, as described above.
- Default Selection for Receipt of New Leave Transfer (or Other Lump Sum Transfer). If the Employee does not timely return a completed, signed election form to the Trust Office within the time period indicated in the notice or information packet, the Trust Office will implement the default selection for the new Lump Sum Transfer funds based upon the Employee's age on the day after the deadline for delivery of the election form.
 - If the Employee is 40 years or older, the Trust Office will credit the leave transfer (or other Lump Sum Transfer) to an Individual Account for the Employee.
 - If the Employee is under age 40, the Trust Office will use the current Lump Sum Transfer Conversion Table to convert the leave transfer (or other Lump Sum Transfer) to Active Service Units.
 - The default selection is irrevocable on the day after the election form deadline.

- The default selection does not apply to the opportunity to convert the Individual Account balance.

Note that the Leave Conversion Table may be updated from time to time. Please contact the Trust Office to request a copy of the latest conversion table.

6. Can I select the investments for my Individual Account?

Yes, effective August 1, 2023, the Trustees have implemented investment options for the investment of Individual Accounts. You are only permitted to select an investment option once annually and when your Individual Account is first established. The rules for investment selection and the descriptions of the investment Portfolio options are included in the “Informational Bulletin for Individual Account Investment Selection,” which is included in a packet of documents and is distributed to you when your Individual Account is first established and annually during the annual investment selection period. Please also see Q&A 5 for the circumstances in which you can convert your Individual Account balance into Active Service Units.

If you did not receive the Bulletin or need another copy, please contact the Trust Office. The Trustees reserve the right to change or terminate the investment options for Individual Accounts at any time. We expect the first annual investment selection period from IAFF MERP to be in April 2024 with changes to investment selection effective on July 1, 2024. You must return the Investment Selection Form to the Trust Office by the deadline on the form or your Individual Account will be invested in the default investment selection. See the current Informational Bulletin for description of default investments.

Investment returns are not allocated to an Individual Account with a balance of \$1,000 or less.

7. What items are credited to or debited from the Individual Account?

The following items are credited to your Individual Account balance:

- Lump Sum Transfers from employers, including leave transfers and Option C transfers for San Diego firefighters, unless conversion to Active Service Units is elected;
- Retiree Contributions, i.e., mandatory employer payments made for each retiree in a specified class pursuant to a collective bargaining agreement;

- Surplus Leave Benefits for a Surviving Spouse with termination of benefits prior to receipt of the value of a leave transfer (Q&A 25);
- Contributions for the Surviving Spouse of a Line of Duty Death who elects an Individual Account instead of a monthly benefit (Q&A 14, 16);
- The sum of any Lump Sum Transfers received for Eligible Retiree with Short Service (Q&A 4);
- Investment earnings and losses (generally credited monthly based on the monthly return received by your investment selection in the prior month), as long as the balance is above \$1,000;
- Administrative expenses are deducted from the balance for the costs of administering the Individual Accounts;
- Conversions of the Individual Account balance to Active Service Units will reduce the Individual Account balance;
- Benefit payments are deducted following an Eligible Retiree's claim, including when an Eligible Retiree's claim exceeds his or her Monthly Benefit Level;
- Contributions for the Surviving Spouse of a Line of Duty Death who elects an Individual Account benefit instead of a monthly benefit (Q&A 14, 16); and
- Contributions for an Eligible Retiree with a Disability Pension Benefit who elects an Individual Account benefit instead of a monthly benefit (Q&A 2).

Note Regarding Administrative Expenses Charged to Individual Accounts. All plan participants share the cost of operating the IAFF MERP (e.g., auditing, claims administration, insurance, legal advice, etc.). The Pooled Account generally pays all operating expenses. However, Account Beneficiaries with an Individual Account who are not currently participating in the Pooled Account (either through current monthly contributions or monthly benefits) are required to pay an administrative maintenance fee deducted from the Individual Account Balance to pay for their proportionate share of operating expenses of the IAFF MERP. Based on estimated costs to operate the IAFF MERP, the Trustees have set the administrative maintenance fee for Limited Beneficiaries who do not have any participation in the Pooled Account, at \$8 per month (effective August 1, 2023). Other Account Beneficiaries with an Individual Account, who are also currently participating in the Pooled Account, are required to pay an administrative maintenance fee that reflects the extra costs of administering Individual Accounts. These Account Beneficiaries with an Individual Account, who are also participating in the Pooled Account, will be assessed an administrative maintenance fee of \$3 per month for the cost

of maintain the Individual Account (effective August 1, 2023).⁵ The Trust Office will show the administrative maintenance fee as a line item in the Individual Account transactions on the IAFF MERP web portal.⁶

8. What items are credited to the Accumulated Benefit?

The following items are credited to the Accumulated Benefit and do not earn interest or investment returns:

- Unused monthly benefits (See Q&A 17); and
- Contributions made on behalf of an Employee who does not make the minimum years of Active Service for monthly benefit eligibility, i.e., Eligible Retiree with Short Service (Q&A 4).

9. What are the benefits from the Plan?

After meeting the eligibility requirements, Eligible Retirees are entitled to reimbursement toward the payment of Covered Expenses, which generally consist of health insurance premiums and medical expenses paid and incurred by the Employee after the Employee retires and becomes eligible for benefits under IAFF MERP. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment for a Beneficiary who qualifies for the lifetime⁷ stream of benefit payments is limited to the Beneficiary's Monthly Benefit Level. See Q&A 11. However, for an Employee who does not earn the five years of Active Service, his/her benefits are limited to his or her Accumulated Benefit and/or Individual Account. See Q&A 4.

Cost Sharing. It is important to remember that IAFF MERP reimburses toward the cost of Covered Expenses, but your Monthly Benefit Level, Individual Account, or Accumulated Benefit may not cover the entire amount of the Covered Expense. If your Monthly Benefit Level, Individual Account, and/or Accumulated Benefit does not cover the entire cost of your Covered Expense, you will be responsible for the balance of any Covered Expense.

⁵ This is because participants in the Pooled Account pay their portion of the IAFF MERP operating expenses through payment of operating expenses from the Pooled Account. However, there are extra administrative expenses to operate Individual Accounts that participants in the Pooled Account, who do not have an Individual Account, are not required to subsidize.

⁶ The Trustees have authority to adjust the administrative maintenance fee up or down at any time based upon the actual operating expenses of the IAFF MERP. The Trustees also have the authority to determine whether to charge the administrative maintenance fee monthly, quarterly, or annually.

⁷ See footnote 2.

Benefits Limited to Reimbursement of Covered Expenses. Note that IAFF MERP is not allowed under federal law to distribute unrestricted cash; it can only reimburse for tax-deductible and verified medical expenses that meet the definition of “Covered Expense.” This also means that you cannot rollover your benefit payments into an Individual Retirement Account (IRA) or other retirement plan.

10. What type of medical expenses will be reimbursed by IAFF MERP?

The following medical expenses are considered Covered Expenses, and will be reimbursed by IAFF MERP:

- Premium or contribution payments for coverage under medical, dental, or vision insurance that qualify as medical care under Internal Revenue Code (“Code”) Section 213(d), including Medicare supplemental plans. As of January 1, 2024, the Plan will allow for reimbursement of premiums paid with pre-tax-income.⁸ However, in this circumstance the IRS requires the Plan to issue a Form 1099 to the Plan participant to show that he or she has received taxable income from the Trust. The claim form requires that you request taxable benefit payment in order to receive reimbursement of premiums paid with pre-tax income.
- Medical expenses excludable from gross income under Code Section 213(d), i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs. For a list of examples of deductible and nondeductible medical expenses, see IRS Publication 502, which you can find at www.irs.gov/pub/irs-pdf/p502.pdf
- Premium payment for long-term care insurance as qualified for tax deduction under Code Section 7702B.

See Plan Section 1.9 for a full definition of Covered Expenses.

Please note that a payment to a health care sharing ministry, such as Samaritan ministries, Christian Care Ministry’s Medi-Share program, or Christian Healthcare Ministries, does NOT qualify as a Covered Expense. This is because a payment, contribution or gift to a health care sharing ministry does not fit within the IRS rules for a tax-deductible insurance

⁸ For example, your spouse’s employer deducted the premium from your spouse’s salary or wages prior to calculating the spouse’s taxable income (like from a cafeteria plan). Thus, the amount of your spouse’s income deducted for premium payment will not be reported on a W-2 form and will not be taxable income to you or your spouse.

premium or medical expense. The Trust must comply with these rules in order to preserve the tax benefits of IAFF MERP for all participants.

If you have a question about whether an expense will qualify for reimbursement, you may contact the Trust Office at (425) 367-0743.

11. How is my Monthly Benefit Level calculated?

An Eligible Retiree's Monthly Benefit Level is determined by the number of Active Service Units he/she has accrued during his/her employment (or has accrued because of conversion of leave transfer, other Lump Sum Transfer, or Individual Account balance) and the Unit Multiplier that is operative, as set forth in Appendix B (at the end of this Summary).

- An Employee earns Active Service Units for each Contribution to the Plan. Each monthly Contribution of \$25 is equal to one Active Service Unit. For example, if your Local's monthly Contribution rate is \$75, you will earn three Active Service Units per month.
- The Unit Multiplier is a factor set by the Trustees, with actuarial advice, which allows the Plan to pay benefits for the lifetime of all Eligible Retirees who qualify for the lifetime stream of benefits.⁹

After retirement, the Trust Office will calculate your Monthly Benefit Level by the following methodology (as further described in Plan Section 3.2, and illustrated in Appendix A of the Plan and attached hereto):

- Determine your total number of Active Service Units, and
- Multiply your total number of Active Service Units by the Unit Multiplier that is operative, as set forth in Appendix B (at the end of this Summary).

From time to time, the Trustees will determine the Unit Multiplier, as defined in Plan Section 1.34, with the assistance of professional actuarial advice. You may contact the Trust Office to find out the current Unit Multiplier, which may increase or decrease from time to time.

⁹ See footnote 2.

12. What is the difference between “Active Service” and “Active Service Units” (or ASUs)?

- Active Service reflects periods of employment when your employer transfers Contributions to the Plan on your behalf. Your length of Active Service is one of the factors that determine your eligibility for monthly benefits as an Eligible Retiree.
- “Active Service Units” reflect the number of \$25 Contributions made on your behalf to the Plan. The number of Active Service Units is a factor in determining the amount of your Monthly Benefit Level.

13. Why are there differences in the Monthly Benefit Level between participants?

An Eligible Retiree’s Monthly Benefit Level is calculated by the methodology described in Q&A 11 above. Each Eligible Retiree’s Monthly Benefit Level will be affected by the number of Active Service Units earned by that Employee over his or her career (and by any conversions of Lump Sum Transfers and/or Individual Account balance to Active Service Units). An Employee earns one Active Service Unit for each monthly Contribution of \$25 to the Plan on his or her behalf. The monthly Contribution rate is negotiated by the Employee’s bargaining unit. For example, a monthly Contribution rate of \$75 will provide to each employee in that bargaining unit three Active Service Units per month, whereas a monthly Contribution rate of \$100 will earn four Active Service Units per month. Thus, Eligible Retirees from different Locals will have different Monthly Benefit Levels, depending upon what Contribution rate their Local selected and negotiated, or whether accrued leave (or other Lump Sum Transfer) was transferred to the Plan and converted to ASUs. Even within the same Local, Monthly Benefit Levels may vary based on the Employee’s period of Active Service in the Plan, or how much leave (or other Lump Sum Transfer) he/she may have contributed to the Plan.

14. Will my Monthly Benefit Level remain constant for my lifetime?

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

Choices on Retirement: Monthly Benefit Level Options.

Application for Your Benefits. You should receive a retirement packet of forms within two (2) weeks of your employer's notification to the Trust Office of your retirement or separation from employment. Eligible Retirees who become eligible *on or after* August 20, 2014, may select from four different Monthly Benefit Level options at the time that they first apply for benefits. Option 1 provides a constant Monthly Benefit Level for your lifetime using the basic benefit level formula provided above (See Q&A 11). Each of the next three options allows you to select a higher Monthly Benefit Level immediately after you first apply for IAFF MERP benefits until age 65 and a reduced Monthly Benefit Level after age 65. Option 4 has the highest Monthly Benefit Level before age 65 and the lowest Monthly Benefit Level after age 65.

Specifically, the four options for an Eligible Retiree are as follows:

- OPTION 1: A constant Monthly Benefit Level for life. Option 1 provides the highest Monthly Benefit Level after age 65.
- OPTION 2: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Option 1. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than the Option 1 Monthly Benefit Level that he/she would receive after age 65.
- OPTION 3: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Options 1 and 2. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than either the Option 1 or 2 Monthly Benefit Levels that he/she would receive after age 65.
- OPTION 4: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Options 1, 2, and 3. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than the Options 1, 2, or 3 Monthly Benefit Levels that he/she would receive after age 65. Option 4 provides the highest Monthly Benefit Level before age 65, but results in the lowest Monthly Benefit Level after age 65.

In Options 2-4, your Monthly Benefit Level will be reduced at age 65, with Option 2 having the lowest percent reduction at age 65 and Option 4 having the highest

percent reduction at age 65. You will be asked to select from among these options when you commence your benefits. Once you make your selection, you cannot change that selection and the selection will apply to any survivor's benefit as well.

Your selection will depend upon your own unique circumstances. Factors to consider include, but are not limited to, your financial needs and goals, as well as those of your beneficiary(ies), sources of income in your retirement, and your health and age at retirement.

- Default Option. If you do not make a choice within the deadline included in the retirement packet, then you will automatically be defaulted into Option 1, which is the constant Monthly Benefit Level for life.

As with all decisions related to retirement, we suggest you consult with an independent financial advisor, prior to making this decision. Although it may seem like a good idea to have a higher amount right away when you retire until age 65, we suggest you bear in mind the following:

- You may need the money more after age 65;
- You may not be able to work as much after age 65;
- Medigap policies (which many retirees purchase to supplement coverage under Medicare) may increase in price;
- You may live a long time after age 65, and a higher benefit could come in handy.

If you die before you make a selection (and before the default option is implemented), your Beneficiary will have the opportunity to select from Options 1-4 for calculation of the Monthly Benefit Level and to select the length of the Surviving Spouse benefit, i.e., a benefit that ends at Medicare eligibility or a lifetime benefit (See Q&A 16). The Surviving Spouse of a Line of Duty Death has the option of a Monthly Benefit Level (See Q&A 16) or an Individual Account benefit, i.e., to elect to have the Contributions made on behalf of the Employee added to an Individual Account.

The Trust Office will provide you information with the specific amounts in each Option when you reach retirement age and apply for benefits from the Plan. For examples illustrating the four options, see Appendix D to the Plan, attached hereto.

15. How long will benefits continue for my Surviving Spouse and Children?

Regular Beneficiaries, who retire or terminate employment on or after March 15, 2023, have the choice at retirement of whether their Surviving Spouse will have a monthly benefit for the spouse's lifetime or until the spouse attains Medicare Eligibility. If the Eligible Retiree elects a lifetime Surviving Spouse benefit, the Eligible Retiree's Monthly Benefit Level (under all Options 1-4) will be actuarially reduced. If the Eligible Retiree and spouse elect a Surviving Spouse benefit that terminates at Medicare Eligibility, the Eligible Retiree's Monthly Benefit Level (under all Options 1-4) will be higher than if the lifetime Surviving Spouse benefit is elected (i.e., the actuarial reduction is not applied).

The Trust Office will send you a retirement packet that quotes your Monthly Benefit Level under each Option 1-4 with and without a lifetime Surviving Spouse benefit. If you are electing a Surviving Spouse benefit terminating at Medicare Eligibility and you are married, your spouse must sign the Election Form in front of a notary public. If you do not return the Election Form to the Trust Office by the deadline stated in the packet, or you return the packet but do not make a valid election on Surviving Spouse benefits, you will receive the default election, which is a lifetime Surviving Spouse benefit, and your Monthly Benefit Level will be actuarially reduced accordingly.

If the Employee attained age 53 prior to death, the Surviving Spouse and Child benefits commence the month after the death of the Eligible Retiree or Employee. The Surviving Child, or his or her legal guardian, is entitled to submit his or her own claims for benefits if there is no Surviving Spouse. If the Employee did not attain age 53 prior to his or her death, then the Surviving Spouse and/or Child shall be entitled to benefits for 24 consecutive months starting the month after the death (or he/she may elect a later start date). After 24 consecutive months have passed since the benefit start date (whether benefits are paid each month or not), the benefit payments will be suspended until the date that the Employee would have attained age 53. If that date occurs during the 24-month period of benefit eligibility, then the benefit payments will not be suspended. This suspension of benefits does not apply to benefits of a Surviving Spouse of an Eligible Retiree who had an actuarially reduced Monthly Benefit Level due to starting benefit payments prior to age 53 (for Employees who are eligible for Regular Pension Benefits or Disability Pension Benefits prior to age 53). In this circumstance, the Surviving Spouse benefit payments will start the month after the death of the Eligible Retiree calculated based upon the Eligible Retiree's actuarially reduced Monthly Benefit Level. If the Employee suffered a Line of Duty Death, then the benefit payments will also not be suspended after 24 months. Line of Duty Death is defined as a death that the applicable IAFF District Vice President has approved as a line of duty death. See Plan Section 1.17.

Benefits from a Surviving Spouse's or Surviving Child's Accumulated Benefit or Individual Account cease when the Surviving Spouse or Surviving Child has exhausted his or her Accumulated Benefit or Individual Account balance, or at the time that the Surviving Children no longer meet the definition of Child (i.e., under age 26).

16. What will the Monthly Benefit Level be for my spouse and children in the event of my death?

The Monthly Benefit Level for a Surviving Spouse is equal to 50% of the Monthly Benefit Level of the deceased Eligible Retiree. If there is no Surviving Spouse, the Monthly Benefit Level for Surviving Children will be 50% of the Monthly Benefit Level for the deceased Eligible Retiree (to be divided among the Children). The deceased Eligible Retiree's Monthly Benefit Level is determined based upon the Option and Surviving Spouse benefit length that he or she selected at eligibility.

If the Employee or Eligible Retiree died before selecting an Option and/or Surviving Spouse benefit length, and before the deadline for election resulted in a default election, the Trust Office will send the Surviving Spouse a retirement packet offering the Surviving Spouse the right to make an election among Options 1-4 and the right to make an election of Surviving Spouse benefit length. A Surviving Spouse of an Employee who suffered a Line of Duty Death may elect among the same Options 1-4 and Surviving Spouse benefit length; or elect to credit the total Contributions made on the Employee's behalf to an Individual Account. Any Surviving Spouse who does not make an election within the time period provided in the retirement packet will receive a Monthly Benefit Level calculated based upon the default of Option 1 with a lifetime Surviving Spouse benefit.

Additionally, any Accumulated Benefit or Individual Account balance remaining upon a Beneficiary's death will be available to the Surviving Spouse and/or Surviving Children.

A Surviving Spouse or Surviving Child also has the option to use his or her monthly benefits to reimburse the Covered Expenses incurred by a deceased Beneficiary prior to the Beneficiary's death.

Children include the natural children, adopted children, and stepchildren of the Eligible Retiree who are under the age of 26. Children who are over the age of 26 and who are legally dependent upon the Eligible Retiree and determined to be permanently and totally disabled by the Social Security Administration are also eligible Beneficiaries at any age. Spouse includes all lawful spouses, same or opposite sex. Surviving Spouse means a

lawful spouse to whom the deceased Employee or Eligible Retiree had been married for at least 12 months on the date of his or her death.

Note that the Surviving Spouse or Surviving Child of an Eligible Retiree who did not qualify for the lifetime stream of monthly benefits will not be entitled to a monthly benefit. Instead, such Surviving Spouse or Surviving Child will be entitled to reimbursement of Covered Expenses as an Account Beneficiary from the Individual Account balance or from the remaining Accumulated Benefit following the death of the Eligible Retiree. The benefits will continue until the Accumulated Benefit and/or Individual Account balance has been exhausted. The Surviving Spouse and/or Surviving Child of an Employee who suffered a Line of Duty Death has the option to elect a Monthly Benefit Level for benefit payments or an Individual Account equal to the total Contributions made on the deceased Employee's behalf (without any allocation for prior investment returns thereon) plus any mandatory transfer of sick and/or vacation leave.

Please note: The Plan provides benefits for legal spouses, who are either opposite or same sex. Due to the cost of compliance with federal tax regulations regarding domestic partners, the Plan does not provide benefits for domestic partners or surviving domestic partners.

17. What happens if I don't use my full Monthly Benefit Level each month?

If an Eligible Retiree does not use his/her entire Monthly Benefit Level for one month, then the unused amount of his/her Monthly Benefit Level, including unused benefits from periods when an Eligible Retiree's monthly benefits are suspended due to return to employment with a Participating Employer, will be added to what is known as the Accumulated Benefit (see Plan Section 1.3 for the definition of Accumulated Benefit). The Accumulated Benefit represents a total dollar amount of benefits that the Eligible Retiree and his/her surviving Beneficiaries can use for reimbursement of Covered Expenses in addition to his/her Monthly Benefit Level and/or Individual Account.

Please note that the Accumulated Benefit does not earn interest and it is available until the Accumulated Benefit amount is exhausted, i.e., there is no age requirement for Accumulated Benefit reimbursements, except that a Surviving Child must qualify as a Child (i.e., under age 26 or disabled, as defined in the Plan).

18. What happens if I have high monthly Covered Expenses in one month? Can I get the excess Covered Expenses reimbursed in a later month?

Yes. If you submit a claim for Covered Expenses that exceeds your Monthly Benefit Level plus Accumulated Benefit and Individual Account, the Trust Office will reimburse you for those excess expenses in a subsequent month when you have not submitted claims sufficient to use all of your Monthly Benefit Level. Monthly reimbursement cannot exceed the Monthly Benefit Level plus the Accumulated Benefit and Individual Account balance of the Beneficiary. For example, if your Monthly Benefit Level is \$200 and you submit a claim for a Covered Expense of \$300, then you would receive payment for that claim at \$200 in the first month, and \$100 in the next month (provided your Accumulated Benefit balance is \$0). If you submit claims of \$300 in the first month, \$200 in the second month, and no claims in the third month, then you will receive reimbursement for the excess \$100 in the third month (provided your Accumulated Benefit balance is \$0). If you have an Accumulated Benefit of \$100 because you only used a portion of your prior Monthly Benefit Level, then a claim of \$300 would be reimbursed \$200 from your Monthly Benefit Level and \$100 from your Accumulated Benefit in the first month – leaving a new Accumulated Benefit of \$0. Any excess Covered Expense is carried over and reimbursed in a month when you have not submitted claims equal to your Monthly Benefit Level plus Accumulated Benefit and Individual Account.

This claim carryover from month to month provides an option for Eligible Retirees to submit proof of premium payment less frequently than monthly. If the proof of premium payment shows payment of a premium amount that exceeds the Eligible Retiree's monthly Benefit Level, the Eligible Retiree may be able to wait a couple of months before submitting another proof of premium payment. For example, if an Eligible Retiree's monthly Benefit Level is \$300 and he/she submits proof of payment of a monthly premium of \$1,800, the Eligible Retiree would receive reimbursement of that premium for up to 6 months without submitting another proof of premium payment. After the \$1,800 is fully reimbursed, the Eligible Retiree will need to submit another proof of premium payment in order to continue receiving his/her benefit payment monthly.

19. How do I submit my claims for benefits?

To present a claim for benefits under this Plan, a Beneficiary must submit a claim on a form approved by the Trustees to the Trust Office no later than March 31st of the year following the year in which the Beneficiary paid the Covered Expense. For example, all Covered Expenses which the Beneficiary paid in the calendar year 2023 must be submitted for reimbursement no later than March 31, 2024. (While the Trust Office may waive the

deadline for good cause shown, please do not assume that any circumstances will constitute good cause.) The Plan encourages you to submit claims and receive reimbursements throughout the plan year.

Please note that, in accordance with the rules of the Plan, the Trust Office requires that you provide third-party documentation of the type and amount of the expense and proof of payment by a Beneficiary before issuing a reimbursement benefit payment. Beneficiaries may contact the Trust Office to request an approved claim form. You must submit your claim to the Trust office at:

IAFF Medical Expense Reimbursement Plan
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Fax: (866) 676-1530
Email: iaff-merp@vimly.com
Website: <https://iaff-merp.simon365.com>

Documentation Needed For Each Claim.

For medical expense claims that are not insurance premium payments, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates that medical services or supplies were provided (which date must be prior to submission of the claim);
- A description of the medical services or supplies, which must qualify as a tax-deductible expense;
- Proof of the Beneficiary's payment of the medical expense, which can include one of the following or other proof approved by the Board of Trustees:
 - Canceled check drawn to the name of the medical services or supplies provider, bank statement showing check payment, or credit card statement showing payment;
 - Copy of confirmation of electronic payment to the medical services or supplies provider; or
 - Receipt for payment from the medical services or supplies provider.

For insurance premium payment claims, at least annually, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates of coverage for insurance premiums.
- A description of the insurance premiums, i.e., type of insurance provided.

The annual claim form will advise the Trust Office of the premium amount that you will be paying for the upcoming year, and the amount that you are claiming for reimbursement from the Plan for those monthly premiums. If you have a change in premium amount before the next annual claim form collection date (e.g., due to eligibility for Medicare or adding/deleting a family member to/from your policy), then you need to submit a new claim form to the Trust Office. If you want reimbursement of premiums that you paid with pre-tax income, e.g., premiums deducted by an employer from your spouse's wages, you must indicate this request on the claim form and acknowledge that you want a taxable benefit payment. Please contact the Trust Office for a claim form or download a copy on the Trust's website.

Documentation Needed for Each Premium Reimbursement (Monthly). To receive reimbursement of recurring monthly premiums (except for Medicare premiums deducted from Social Security payments), you must also submit the following information each time you want reimbursement. This is in addition to the annual documentation with the claim form described above. Generally, you must submit proof that a Beneficiary has paid the premium each month, and the payment amount must match the amount claimed on your annual claim form.

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 the annual claim form and third-party insurance documentation of your premiums.

Claim Payments Must Reimburse Prior Covered Expense Payments. All reimbursement payments must reimburse your prior Covered Expense payment, not a prospective payment. If you request reimbursement of insurance premiums, you may be reimbursed in the month following the month in which you paid the insurance premium depending upon the date in the month that you pay your premiums.

You may *not* submit claims for medical expenses that have been paid, or you expect to be paid, by another source, such as Medicare, a supplemental health insurance plan, or a Health Savings Account (HSA). If such double coverage is discovered, the Trust may pursue recoupment, penalties and interest against you.

In the event the Trust overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments until the Trust has recouped the total overpaid amount, or the Trust may seek repayment of the total overpaid amount from you directly to the Trust.

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Details for claim submission and appeal of claim denial are set forth in Section 3.6 and Section 4 of the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

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

To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, a Beneficiary must submit a written request to the Trust Office within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. An appeal is considered submitted and filed with the Trust Office on the date that it is received/date stamped at the Trust Office. The Board of Trustees will hold a hearing on the appeal, and the Beneficiary will be entitled to present his or her position and any evidence in support of his or her appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision.

The 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.

You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

21. What is a Qualified Domestic Relations Order (“QDRO”) or Qualified Medical Child Support Order (“QMCSO”) and who pays the costs of evaluating and implementing a QDRO or QMCSO?

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

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 the Monthly Benefit Level, Individual Account, and Accumulated Benefit 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, Individual Account, and Accumulated Benefit 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 Eligible Retiree 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 written explanation of such procedures and a copy of the model QDRO with their benefit information inserted, including the actuarially adjusted Monthly Benefit Level of the ex-spouse of the

Participant. (You may also submit your own proposed QDRO, but it will be subject to review and approval by the Plan.)

A QMCSO is an order issued by a state court or agency that may require a health plan subject to ERISA to provide health benefits to children.

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

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

Yes. The time limit for a Beneficiary to bring action in federal court pursuant to ERISA Section 502(a) is no later than one year after the exhaustion of administrative remedies (i.e., the appeal process in Q&A 20), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court. The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits, and the Trustees anticipate that an action brought in federal court challenging the Trustees' exercise of their discretionary authority will be subject to a deferential standard of review.

23. What is the Plan Year?

The Plan Year runs from July 1 through June 30.

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

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

- Changes in your mailing address, cell phone number and personal email address;
- Changes in your employment status (e.g., retirement, lay-off, or reduction in hours);
- Changes in your spouse (e.g., divorce, marriage, or death); and

- 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.

25. What are the circumstances that may result in ineligibility or denial of benefits; or amendment or termination of the Plan?

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 expense receipts, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note the following events will cause termination of benefits:

- An Eligible Retiree's benefits under this Plan will be suspended upon return to employment with a Participating Employer; provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with Participating Employers.
- An Eligible Retiree's benefits under this Plan will terminate upon his/her death.
- A Surviving Spouse's benefits under this Plan will terminate on the date of death of the Surviving Spouse, unless the Eligible Retiree elected a Surviving Spouse benefit terminating at Medicare Eligibility. However, there is one exception to this termination at Medicare Eligibility in regard to Lump Sum Transfers , as follows:
 - Transfer of sick/vacation leave into Plan – Surplus Leave Benefits. If the former employer of the Eligible Retiree transferred a Lump Sum Transfer, such as accrued sick or vacation leave, into the Plan, the Eligible Retiree elected to convert that leave into Active Service Units, and the Eligible Retiree elected a Surviving Spouse benefit terminating at Medicare Eligibility, there may be a Surplus Leave Benefit for the Surviving Spouse on the Eligible Retiree's death. In this circumstance, the Trust Office will determine whether the Retiree received the full value of his/her sick leave transfer prior to death. If the value of benefits received was less than the Lump Sum Transfer, then the Trust Office will calculate the Surplus Leave Benefits, using actuarial factors, and the Surviving Spouse can receive benefits after Medicare Eligibility up to the

amount of Surplus Leave Benefits. The Trust Office will add the Surplus Leave Benefits to the Individual Account.

For example, the Trust Office received a leave conversion of \$4,000, which added \$50 per month to the monthly benefit. If the Eligible Retiree and Surviving Spouse received that extra \$50 per month for only 10 months, then they received only \$500 in added value from that leave transfer, and the Surviving Spouse will be entitled to Surplus Leave Benefits. The Surplus Leave Benefits will be actuarially calculated and may not equal \$3,500, but the Surviving Spouse will receive some added benefits in an Individual Account after Medicare Eligibility in order to receive the value of the leave transfer. See Plan Section 3.4(b)(2).

- A Surviving Child's benefits under this Plan will terminate upon the loss of Child status or death, whichever occurs first.
- A Beneficiary's Individual Account or Accumulated Benefit will terminate when the amount of the Individual Account or Accumulated Benefit reaches zero or on the death of all Beneficiaries, whichever occurs first, except that the Individual Account or Accumulated Benefit of a Surviving Child will terminate upon loss of Child status.

Benefit coverage and benefit levels may be modified or terminated pursuant to Section 6 of the Plan and such changes may apply to all or some current and/or future Beneficiaries.

26. Can my benefits be reduced by Plan amendment or termination?

Yes. The Trustees reserve the right to modify benefit coverage and Monthly Benefit Levels, any other provision of the Plan or 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.

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

No. The Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Covered Expenses you will submit to the Plan for payment. The Plan will

not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. Details of this restriction are in Plan Section 3.7. (There is an exception for incompetent Beneficiaries with a court appointed representative. See Plan Section 3.6(f).)

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

Greg Markley, Chair	Mike Frainier, IAFF Trustee
Dennis Lawson, Secretary	Matt Martens
Mike Westland	Craig Soucy
Bill Dodds	Jeff Wainwright
Ricky Walsh	Judson McCauley
Greg Wilson	Mike Detoy

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Drive, #105
P.O. Box 6
Mukilteo, WA 98275

29. Is there any other information about the Plan I should know?

A. The name of the Plan and Trust.

This Plan is known as the “IAFF Medical Expense Reimbursement Plan of the Washington State Council of Fire Fighters Employee Benefit Trust,” restated effective August 1, 2023, and as amended from time to time thereafter (the “Plan,” *Dr. 3/3/23*). The Plan is governed by the “Trust Agreement Governing the Washington State Council of Fire Fighters Employee Benefit Trust,” restated effective July 1, 2018, and as amended thereafter (the “Trust Agreement” *7/28/18 Ed.*). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

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

The Plan was established by the Washington State Council of Fire Fighters (“WSCFF”), which is an organization located within the state of Washington that represents affiliated local fire fighter unions of the IAFF.

The name, address and telephone number of the WSCFF is as follows:

Washington State Council of Fire Fighters
1069 Adams Street Southeast
Olympia, WA 98501
(360) 943-3030

C. The identification numbers of the Trust and Plan.

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 91-2009771. The Plan number is 501.

D. The type of plan.

The Plan is a welfare benefit plan providing reimbursement for health insurance premiums and medical expenses to retirees. Beneficiaries may refer to Internal Revenue Service Publication 502, or check with the Trust Office to determine if a premium and/or medical expense is a Covered Expense under the Plan, eligible for reimbursement under the Plan.

E. The type of administration/trust office.

The Plan is administered by the Board of Trustees of the WSCFF Employee Benefit Trust. The Board has retained the services of a contract administrator to assist in recordkeeping, claims payments, etc. You may contact the Board of Trustees in care of the Trust Office. The contact information of the Trust Office is:

IAFF Medical Expense Reimbursement Plan Trust Office
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743
Fax: (866) 676-1530
Email: iaff-merp@vimly.com
Website: <https://iaff-merp.simon365.com>

F. The identity of the Plan Administrator.

The Plan Administrator (fiduciary) is the Board of Trustees IAFF Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust. The Trustees may be contacted in care of the Trust Office.

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

The Plan is maintained pursuant to various collective bargaining agreements and successor agreements between the participating Locals and their respective employers. Beneficiaries of the Plan (i.e., employees, eligible retirees, surviving spouses, and children), as defined in the Plan and Trust documents, may obtain copies of these collective bargaining agreements upon written request to the Trust Office. Further, these agreements are available for examination by Beneficiaries at the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the collective bargaining agreements. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

H. Information regarding the Family Medical Leave Act.

Please contact the Trust Office and/or your Employer if you would like to learn more about the right to self-pay contributions during Family and Medical Leave Act (“FMLA”) leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

I. Information regarding Veterans’ Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

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

J. Information regarding COBRA.

The General COBRA Notice is attached hereto. However, if you would like to request a separate 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 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:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Fax: 866-601-4397
Email: iaff-merp@vimly.com

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.

K. The source of Contributions to the Plan.

Contributions to this Plan must be non-elective; i.e., no individual employee election. Instead, they must be required by a collective bargaining agreement. They may be employer and/or employee Contributions. Further, under certain limited circumstances required by federal law, Beneficiaries may elect to make self-payment contributions.

L. The method that is used for the accumulation of assets.

Contributions are received and held in trust by the Trust and are invested 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) requirements.

M. The procedures governing Qualified Medical Child Support Order Determinations (QMCSO).

Beneficiaries can obtain, without charge, a copy of such procedures from the Trust Office.

N. The name and address of the agent for service of process.

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

IAFF Medical Expense Reimbursement Plan Trust Office
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

O. Statement of Legal Rights.

- Rights of Plan Participants. Beneficiaries of the IAFF MERP are entitled to certain rights and protection under the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
 - Examine without charge at the Plan Administrator's Office and at other specified locations such as worksites and union halls, all documents governing this Plan, including collective bargaining agreements, insurance contracts and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
 - Obtain upon written request to the Plan Administrator copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
 - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.

- If there is a cessation of Contributions to the Plan as a result of a COBRA qualifying event, you or your Spouse or your Children may be allowed to continue such contributions by self-payment. Review the General COBRA Notice and Plan Sections 2.2(c) and 2.2(d), for rules governing your COBRA continuation coverage rights.
- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of this employee welfare benefit plan.

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

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

Under ERISA there are steps that can be taken to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, or if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a state or federal court after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim to be frivolous.

- Assistance With Your Questions. If you have any questions about this Plan, you should contact the Plan Administrator or Trust Office. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington DC 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). You may find answers to your questions at <http://www.dol.gov/ebsa/welcome.html>.
- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special precautions of health benefit plans to protect the privacy of “protected health information.” In the course of providing benefits to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. If you would like more details about your privacy rights, please contact the Trust Office, or see the HIPAA notice attached hereto.

APPENDIX A to IAFF Medical Expense Reimbursement Plan
Examples of Calculation of Benefit Level

These examples illustrate how to calculate the Monthly Benefit Level for an Eligible Retiree who elects Option 1 under the Plan, i.e., a Monthly Benefit Level that remains constant for the life of the Eligible Retiree. For examples of how to calculate the Monthly Benefit Level for an Eligible Retiree who selects one of the other options, see Appendix D. Please note that these are examples only – your monthly Contribution rate and length of participation will differ, so your Monthly Benefit Level will be different than in these examples.

\$25 monthly Contribution = 1 Active Service Unit
Unit Multiplier for all eligible Beneficiaries = \$0.41*

Example #1 – 6 years in Plan: A Local has a Contribution rate of \$100/month, and Employee #1 participates for two years (or 24 months) at that amount. Then the Local increases the Contribution rate to \$150/month, and Employee #1 participates for four years (or 48 months) at that amount, and then retires. Employee #1's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.

\$100/month = 4 Active Service Units/Month

\$150/month = 6 Active Service Units/Month

Step 2: Find number Active Service Units.

4 Active Service Units x 24 months = 96 Active Service Units

6 Active Service Units x 48 months = 288 Active Service Units

Total = 384 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.

Monthly Benefit Level: 384 x \$0.41 = \$157.44

Example #2 – 13 years in Plan: A Local selects a Contribution rate of \$100/month, and Employee #2 participates for seven years (or 84 months) at that amount. Then the Local increases the Contribution rate to \$200/month, and Employee #2 participates for five years (or 60 months) at that amount, and then retires. Employee #2's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.

\$100/month = 4 Active Service Units/Month

\$200/month = 8 Active Service Units/Month

Step 2: Find number Active Service Units.

4 Active Service Units x 84 months = 336 Active Service Units

8 Active Service Units x 60 months = 480 Active Service Units

Total = 816 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.

Monthly Benefit Level: 816 x \$0.41 = \$334.56

Example #3 – Career Employee - 20 years in Plan: A Local has a Contribution rate of \$100/month, and Employee #3 participates for seven years (or 84 months) at that amount. Then the Local increases the Contribution rate to \$200/month, and Employee #3 participates for thirteen years (or 156 months) at that amount, and then retires. Employee #3's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.

\$100/month = 4 Active Service Units/Month

\$200/month = 8 Active Service Units/Month

Step 2: Find number Active Service Units.

4 Active Service Units x 84 months = 336 Active Service Units

8 Active Service Units x 156 months = 1248 Active Service Units

Total = 1584 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.

Monthly Benefit Level: 1584 x \$0.41 = \$649.44

**These are examples. The Trustees reserve the right to modify the Unit Multiplier and the formula used to calculate Monthly Benefit Levels at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Plan. For more details, please contact the Trust Office: Vimly Benefit Solutions, (425) 367-0743.*

APPENDIX B to IAFF Medical Expense Reimbursement Plan
Chart of Unit Multiplier Value

Operative Date*	Unit Multiplier (UM)**
September 1, 2009 to June 30, 2012	\$0.42
July 1, 2012 to June 30, 2015	\$0.39
On or after July 1, 2015	\$0.41

**For the three Unit Multipliers used by the Plan to date, the Operative Date refers to the date that the Trust Office paid a claim.*

*** The Unit Multiplier for Eligible Retirees may be adjusted by the Trustees from time to time (see Section 3.2 of the Plan). The amount reimbursed to the Eligible Retiree may not exceed the actual Covered Expense paid by the Beneficiary.*

APPENDIX C to IAFF Medical Expense Reimbursement Plan
Lump Sum Transfer Conversion Table

Effective July 1, 2015

Section 2.2(b) of IAFF MERP sets forth the terms and conditions under which Lump Sum Transfers, including accrued sick and/or vacation leave, and the Individual Account balance, are converted into Active Service Units (“ASUs”). This table provides the cost of each ASU when converting a leave transfer to ASUs.

- The number of ASUs an Employee earns as a result of the Lump Sum Transfer is calculated by the following formula:

Dollar amount transferred divided by the applicable cost for one ASU, as shown in the table below.

- The cost for one ASU depends on a number of factors, including the age of the Employee at the time of the Lump Sum Transfer, the date of election to convert the Individual Account balance, the current Unit Multiplier (see Appendix B above), and other actuarial factors, as determined by the professional actuarial firm engaged by the Trustees.
- This leave conversion table provides a sample calculation for a Lump Sum Transfer of \$1,000 in the 3rd column. Note for comparison purposes that each \$25 monthly Contribution made during active employment gives an Employee one ASU. Thus, \$1,000 in monthly Contributions during active employment would be equivalent to 40 ASUs.

Note that you pay **no taxes** on leave that is transferred into IAFF MERP, and you pay **no taxes** on the reimbursement benefits received from the Plan.

Age on date of receipt of election or default	Cost for One Active Service Unit (“x”)	Number of ASUs Purchased with each \$1,000 Transfer (truncated to whole number)
Age 20	\$7.60	132
Age 21	\$8.11	123

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IAFF Medical Expense Reimbursement Plan
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Age 22	\$8.65	116
Age 23	\$9.22	108
Age 24	\$9.84	102
Age 25	\$10.49	95
Age 26	\$11.19	89
Age 27	\$11.94	84
Age 28	\$12.73	79
Age 29	\$13.58	74
Age 30	\$14.48	69
Age 31	\$15.45	65
Age 32	\$16.48	61
Age 33	\$17.57	57
Age 34	\$18.74	53
Age 35	\$19.99	50
Age 36	\$21.32	47
Age 37	\$22.74	44
Age 38	\$24.25	41
Age 39	\$25.87	39
Age 40	\$27.59	36
Age 41	\$29.43	34
Age 42	\$31.38	32
Age 43	\$33.47	30
Age 44	\$35.70	28
Age 45	\$38.07	26
Age 46	\$40.60	25
Age 47	\$43.30	23
Age 48	\$46.18	22
Age 49	\$49.26	20
Age 50	\$52.53	19
Age 51	\$56.02	18
Age 52	\$59.75	17
Age 53	\$63.72	16
Age 54	\$63.00	16
Age 55	\$62.23	16
Age 56	\$61.42	16
Age 57	\$60.57	17
Age 58	\$59.68	17
Age 59	\$58.74	17

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Age 60	\$57.78	17
Age 61	\$56.77	18
Age 62	\$55.74	18
Age 63	\$54.67	18
Age 64	\$53.56	19
Age 65	\$52.41	19
Age 66	\$51.22	20
Age 67	\$49.99	20
Age 68	\$48.73	21
Age 69	\$47.45	21
Age 70	\$46.13	22

**The Trustees have the authority to modify this table from time to time for future leave transfers.*

APPENDIX D to IAFF Medical Expense Reimbursement Plan
Examples of Calculation of Benefit Level Options

To calculate the adjusted Monthly Benefit Level, you multiply the flat Monthly Benefit Level (Option 1) by the applicable actuarial factor for the Eligible Retiree's age in the Actuarial Factor Table.

Eligible Retirees, who have a retirement date on or after March 15, 2023, must elect between: (a) a lifetime Surviving Spouse benefit with an actuarial reduction to the Eligible Retiree's Monthly Benefit Level under Options 1-4, or (b) a Surviving Spouse benefit that terminates upon the Surviving Spouse attaining Medicare Eligibility with no actuarial reduction to the Eligible Retiree's Monthly Benefit Level under Options 1-4. To calculate the adjusted Monthly Benefit Level with a lifetime Surviving Spouse benefit, you multiply the flat Monthly Benefit Level (Option 1) by the applicable actuarial factor for the Eligible Retiree's age in the Actuarial Factor with Lifetime Surviving Spouse Benefit Table.

A Surviving Spouse benefit that terminates at Medicare Eligibility will still terminate upon the Surviving Spouse's Medicare Eligibility even if the Eligible Retiree is not deceased on the date that the Surviving Spouse has attained Medicare Eligibility.

The Monthly Benefit Levels under Options 2, 3 and 4 depend on a participant's age when he or she retires. The following examples are for a participant who retires under IAFF MERP at age 55. The examples below provide sample calculations of each Option 1-4 with selection of a Surviving Spouse benefit terminating at Medicare Eligibility and the corresponding actuarially reduced benefit option for a lifetime Surviving Spouse benefit. Selection of the Surviving Spouse benefit terminating at Medicare Eligibility requires a notarized signature from the spouse.

Please note: The Eligible Retiree (or surviving Beneficiary if selection not made by Eligible Retiree before death) is provided a retirement packet with information on their own individualized Benefit Levels under all Options and Surviving Spouse benefit combinations and a Benefit Election Form. If the Eligible Retiree does not timely select an Option and Surviving Spouse benefit, by returning the Benefit Election Form to the Trust Office by the deadline, the Trust Office will implement the default selection, which is Option 1 with lifetime Surviving Spouse benefits.

Example #1 – 6 years in IAFF MERP:¹⁰ Consider a 6-year participant at age 55 whose Monthly Benefit Level under Option 1 would be \$157.44 (based on the facts in Appendix A). Here are this participant's Options:

¹⁰ These are examples; each Eligible Retiree's Monthly Benefit Level under these Options will be different. The Trustees reserve the right to modify the Options for the Monthly Benefit Levels and the factors used to calculate the

Option 1: \$157.44 Monthly Benefit Level under IAFF MERP for lifetime*¹¹
\$150.67 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

Option 2: pre-65 Monthly Benefit Level = $\$157.44 \times 1.16493 = \183.41
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$175.52

post-65 Monthly Benefit Level= $\$157.44 \times 0.77662 = \122.27
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$117.01

Option 3: pre-65 Monthly Benefit Level= $\$157.44 \times 1.26963 = \199.89
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$191.29

post-65 Monthly Benefit Level= $\$157.44 \times 0.63482 = \99.95
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$95.65

Option 4: pre-65 Monthly Benefit Level= $\$157.44 \times 1.39501 = \219.63
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$210.19

post-65 Monthly Benefit Level= $\$157.44 \times 0.46500 = \73.21
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$70.06

Example #2 – 12 years in IAFF MERP: Consider a 12-year participant at age 55 whose Monthly Benefit Level under Option 1 would be \$334.56 (based on facts in Appendix A). Here are this participant's Options:

Option 1: \$334.56 Monthly Benefit Level under IAFF MERP for lifetime
\$320.17 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

amount of such Options at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Plan. For more details, please contact the Trust Office: Vimly Benefit Solutions, (425) 367-0743.

¹¹ IAFF MERP is currently written to generally provide benefits for Eligible Retirees until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

Option 2: pre-65 Monthly Benefit Level= $\$334.56 \times 1.16493 = \389.74
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$372.98

post-65 Monthly Benefit Level= $\$334.56 \times 0.77662 = \259.83
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$248.66

Option 3: pre-65 Monthly Benefit Level = $\$334.56 \times 1.26963 = \424.77
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit=
\$406.50

post-65 Monthly Benefit Level= $\$334.56 \times 0.63482 = \212.39
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$203.26

Option 4: pre-65 Monthly Benefit Level= $\$334.56 \times 1.39501 = \466.71
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$446.65

post-65 Monthly Benefit Level= $\$334.56 \times 0.46500 = \155.57
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$148.88

Example #3 – 20 years in IAFF MERP: Consider a 20-year participant at age 55 whose Monthly Benefit Level under Option 1 would be \$649.44 (based on the facts in Appendix A). Here are this participant's Options:

Option 1: \$649.44 Monthly Benefit Level under IAFF MERP for lifetime
\$621.51 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

Option 2: pre-65 Monthly Benefit Level= $\$649.44 \times 1.16493 = \756.55
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$724.02

post-65 Monthly Benefit Level= $\$649.44 \times 0.77662 = \504.37
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit =
\$482.68

Option 3: pre-65 Monthly Benefit Level= \$649.55 x 1.26963 = \$824.69
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = \$789.23

post-65 Monthly Benefit Level= \$649.44 x 0.63482 = \$412.28
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = \$394.55

Option 4: pre-65 Monthly Benefit Level= \$649.44 x 1.39501 = \$905.98
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = \$867.02

post-65 Monthly Benefit Level= \$649.44 x 0.46500 = \$301.99
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = \$289.00

Actuarial Factors Table¹²

Age	Option 2 Pre-65 Factor	Option 2 Post-65 Factor	Option 3 Pre-65 Factor	Option 3 Post-65 Factor	Option 4 Pre-65 Factor	Option 4 Post-65 Factor
39	1.044	0.696	1.067	0.533	1.091	0.364
41	1.051	0.701	1.078	0.539	1.107	0.369
43	1.059	0.706	1.092	0.546	1.126	0.375
45	1.069	0.713	1.108	0.554	1.149	0.383
47	1.081	0.721	1.127	0.564	1.177	0.392
49	1.096	0.731	1.151	0.576	1.212	0.404
51	1.113	0.743	1.181	0.590	1.257	0.419
53	1.136	0.757	1.218	0.609	1.314	0.438
55	1.163	0.775	1.266	0.633	1.389	0.463
57	1.197	0.798	1.328	0.664	1.491	0.497
59	1.242	0.828	1.414	0.707	1.638	0.546
61	1.302	0.868	1.532	0.766	1.863	0.621
63	1.383	0.922	1.710	0.855	2.241	0.747

¹² This Table is a portion of the full Table, which is available from the Trust Office. The factors in this table will vary with each month added to your age. The Trust Office has the full table based on your age in months.

Lifetime Surviving Spouse Benefit Actuarial Factors Table¹³

Factor to Calculate Eligible Retiree Benefit Level with Lifetime Surviving Spouse Benefit	
Retiree's Age in Years At Retirement ¹⁴	Factor (Applied to Retiree Benefit Level under Option Selected)
40	0.985
41	0.984
42	0.983
43	0.982
44	0.980
45	0.979
46	0.977
47	0.976
48	0.974
49	0.972
50	0.970
51	0.968
52	0.965
53	0.963
54	0.960
55	0.957
56	0.953
57	0.950
58	0.946
59	0.942
60	0.938
61	0.933
62	0.929
63	0.924
64	0.919
65	0.913
66	0.908
67	0.902
68	0.897
69	0.891
70	0.886
71	0.880
72	0.874
73	0.868
74	0.861
75	0.854
76	0.848

¹³ These factors were based on the actuarial assumptions used in the benefit level study of the Plan as of 12/31/20.

¹⁴ Age is calculated based upon the Eligible Retiree's closest age on the date of retirement, i.e., 6 months after the birthdate the age is rounded up to the next year.

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Factor to Calculate Eligible Retiree Benefit Level with Lifetime Surviving Spouse Benefit	
Retiree's Age in Years At Retirement ¹⁴	Factor (Applied to Retiree Benefit Level under Option Selected)
77	0.840
78	0.833
79	0.826
80	0.818

APPENDIX E to IAFF Medical Expense Reimbursement Plan
Early Retirement Factors Table

COBRA GENERAL NOTICE

**WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST**

COBRA General Notice

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

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

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of his or her health premium or medical expense costs after separation from employment and attainment of the eligibility age (currently 53)¹⁵ rather than health benefits insurance coverage for former employees of any age. That is, this Plan is for retiree reimbursement health care expense, not insurance coverage.

1. COBRA Generally.

You are a participant in the IAFF Medical Expense Reimbursement Plan (hereafter the “Plan”) of the Washington State Council of Fire Fighters Employee Benefit Trust (hereafter the “Trust”), which provides reimbursement towards certain medical expenses, as defined in the Plan, after reaching the eligibility age and other eligibility requirements. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as “COBRA.”¹⁶

¹⁵ In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay reimbursements for premiums or medical expense to terminated Employees until attainment of age 53, and the COBRA right entitles the Qualified Beneficiary to self-pay contributions to earn additional Active Service and Active Service Units.

¹⁶ Public Law 99-272, Title X.

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUTIONS UNDER COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO REACH 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 Plan by self-payment, when contributions to the Plan would otherwise have ceased because of a certain life event known as a “Qualifying Event.” After a Qualifying Event, the Plan must offer each person who is a “Qualified Beneficiary” the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a Collective Bargaining Agreement or special agreement. By offering a Qualified Beneficiary this right, generally, the Plan is offering that individual the ability to increase his or her benefits from the Plan in one of three ways:

- i) The ability to meet the eligibility requirement to become a Regular Beneficiary and receive a lifetime¹⁷ 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

¹⁷ 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.

- iii) To augment the total benefit amount available under Section 3.2(f) to a participant who does not earn five (5) years of Active Service as defined in Section 2.2.

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

- B. Plan Eligibility Requirements. To be eligible to receive these monthly medical expense reimbursement benefits after attaining eligibility age, this Plan requires that the Employee earn five (5) years of Active Service as 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. An Employee may elect to self-pay COBRA contributions through deduction from a mandatory transfer of accrued leave.

Further, since the Plan also provides for a gradually increasing level of benefits based on the amount 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 7** below. Finally, if you cannot become eligible for the monthly lifetime benefits, you will be eligible for an Accumulated Benefit under Section 3.2(f) of the Plan, which you can access upon separation from employment. (Note that if you make COBRA self-payments under this circumstance, benefit payments will not commence until you have finished making COBRA contributions.)

- C. Consequence of Non-Election. If you do not choose to continue contributions to this Plan and have not earned five (5) years of Active Service, you will not qualify for monthly benefits as a Regular Beneficiary. Instead, you will be eligible to receive the amount of the total contributions submitted on your behalf (without any allocation for investment returns thereon) credited to an Accumulated Benefit, plus any mandatory transfer of sick and/or vacation leave credited to your Individual Account in accordance with Sections 3.2 and 3.5 of the Plan.
- D. 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.

3. Qualifying Events and Qualified Beneficiaries.

A. An Employee as a Qualified Beneficiary. If you are an Employee, you will become a Qualified Beneficiary and have the right to self-pay contributions for yourself (and your beneficiaries), if contributions to the Plan on your behalf cease due to any of the following “Qualifying Events”:

- i) Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or
- ii) Reduction of Work Hours. Your hours of employment are reduced.

Either of these Qualifying Events generally gives you the right to continue self-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 Plan on your spouse’s behalf cease due to any of the following “Qualifying Events,”¹⁸ and provided that the Employee does not elect to self-pay contributions under COBRA*:

- i) Spouse’s Death. The death of your spouse; or
- ii) Termination of Spouse’s Employment. A termination of your spouse’s employment (for reasons other than gross misconduct);
- iii) Reduction of Spouse’s Work Hours. A reduction in your spouse’s hours of employment, provided that your spouse does not elect to self-pay contributions under COBRA; or
- iv) Divorce. If the Employee and spouse divorce during contributions or during benefit payments, a QDRO will provide more rights to ongoing and future benefit payments than COBRA, but this is a Qualifying Event for COBRA.

¹⁸ Some health plans recognize the following Qualifying Events: 1) your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), and 2) you become divorced or legally separated from your spouse. However, due to the structure of this Plan, these are not recognized Qualifying Events.

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 under COBRA, you may become a Qualified Beneficiary and have rights to self-pay contributions to this Plan if contributions to the Plan 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 covered parent; or
 - ii) Termination of Parent's Employment. The termination of the covered parent's employment (for reasons other than gross misconduct);
 - iii) Reduction of Parent's Work Hours. A reduction in the parent's hours of employment, where neither the employee parent nor spouse elect to self-pay contributions under COBRA; or
 - iv) Loss of Child Status. If a Child attains age 26 and loses current reimbursement benefits under the Plan because he/she no longer qualifies as a Child under the Plan.

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 Trust Office has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** must notify the Trust Office 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); or
 - 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; or
 - b) *Contributions to the Plan cease.* The date that contributions to the Plan 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) *Contributions to the Trust Cease.* The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or
- v) 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) or email. The contact information for the Trust Office is as follows:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Fax: 866-601-4397

Email: iaff-merp@vimly.com

The notice of the Qualifying Event should include:

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

When the Plan is notified that one of these Qualifying Events has occurred, it will, in turn, notify you about details concerning your election to continue your contributions to the Plan for the right to receive future benefits.

6. **Maximum Length of COBRA Payments.**

You have sixty (60) days from the date on the COBRA Election Form to mail (postmark) or deliver your COBRA Election Form to the Trust Office. Once you have timely elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within forty-five (45) days of your election. Subsequent periodic payments must be made on a monthly basis and are due on the first of each month, but no later than thirty (30) days following the first of the month. **You will not receive monthly reminders that payment is due.**

- A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment of contributions to the Plan.
 - 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, the COBRA law requires that you be given the opportunity to continue to make contributions to the Plan 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 18-month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to 18 months of self-payment contributions, for a maximum of 36 months. See **Sections 4 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 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 Plan 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 Trust Office 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 or Active Service Units granted based on an erroneous contribution will be rescinded or returned, as the case may be.

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 mail or email address, or phone number appearing below:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Email: iaff-merp@vimly.com

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

10. Address Changes.

In order to protect your family's rights, you should keep the Trust Office 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 Trust Office.

HIPAA NOTICE OF PRIVACY PRACTICES

**WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST**

**NOTICE OF PRIVACY PRACTICES
WITH RESPECT TO PROTECTED HEALTH INFORMATION**

Introduction: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to “protected health information” (“PHI”), which is information that identifies a particular individual and relates to (1) the past, present or future physical or medical condition of the individual; (2) provision of health care to the individual; or (3) payment for the provision of health care to the individual. The Washington State Council of Fire Fighters Employee Benefit Trust (“Trust”) is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the manner in which it may be used or disclosed.

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

1. Our Duties Concerning Protected Health Information:

As the administrative agent for the Board of Trustees of the Trust, we are required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your protected health information. We are also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations, and you can obtain further information by contacting the Privacy Contact Person identified in Section 7 of this Notice.

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

2. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

Except with respect to uses or disclosures of PHI that require an authorization as described in Section 4 of this Notice, we may use or disclose protected health information for purposes of treatment, payment or health care operations, as set forth in Paragraphs 2.A – 2.D below, without your consent. We may elect to obtain your consent to use or disclose protected health information for such purposes, although we are not required to do so. Moreover, such consent shall not be

effective to permit a use or disclosure of protected health care information that requires an authorization as described in Section 4 of this Notice.

- A. Uses and Disclosures for Payment of Medical Expense and Premium Reimbursement Claims. “Payment” includes, but is not limited to, actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to medical expense or premium reimbursement.
- B. Uses and Disclosures for the Payment Activities of Another “Covered Entity.” PHI may be shared with other “covered entities,” which include health care providers and health plans, in certain circumstances. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.
- C. Disclosures to Another Covered Entity for Health Care Fraud and Abuse Detection or Compliance or Health Care Operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and to perform related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains, and the information disclosed pertains to that relationship.
- D. Disclosures to the Board of Trustees of the Trust, as the Plan Fiduciary, as Necessary for Trust Administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

3. Other Uses and Disclosures Permitted or Required Without Authorization:

We may, by complying with the requirements specified in the Privacy Rule, use or disclose protected health information without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

- A. When and to the extent such use or disclosure is required by law.
- B. For public health activities or public health oversight authorized by law.
- C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

- D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.
- E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, or reporting crime in emergencies; or if the information constitutes evidence of criminal conduct on our premises.
- F. For coroners, medical examiners, and funeral directors to perform their legal duties.
- G. For procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.
- H. For research purposes, where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.
- I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.
- J. For specialized government functions related to military personnel, veteran's benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.
- K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.
- L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information, if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

4. Authorization Required for Other Uses and Disclosures:

Uses and disclosures of protected health information other than those identified above will be made only with your written authorization. You may revoke such authorization at any time,

provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or contest the policy itself.

5. Individual Rights:

All participants have the following rights with respect to protected health information that the Plan maintains about them:

- A. Restrictions on Uses and Disclosures. You may request that we restrict uses or disclosures of protected health information under circumstances in which we would be entitled to use or disclose it for the purpose of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care. We are only required to agree to your request if you seek to prevent disclosure to a health plan for the purposes of carrying out payment or health care operations (not for the purpose of treatment), and the protected health information pertains only to a health care item or service for which the plan participant has paid the health care provider out-of-pocket and in full.

Except as described above, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement to restrict certain uses and disclosures with respect to protected health information created or received after notifying you of the termination. Until then, we will be required to abide by the restriction, unless the information is required for purposes such as: giving you emergency treatment; assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name in a health care facility directory if you are incapacitated or in emergency circumstances; or responding to those circumstances described in Section 3 of this Notice, in which an opportunity to agree or object need not be provided.

- B. Confidential Communications. We must accommodate reasonable requests to have protected health information communicated to you in confidence by alternative means or at alternate locations. We may require your request to be in writing, to state (if appropriate) how payment for the accommodation will be handled, to specify an alternative method of contacting you, or to state that disclosure of all or part of the protected health information could endanger you.
- C. Access for Inspection and Copying. You may request access to inspect or copy protected health information that is maintained about you in a designated record

set. If we grant your request, we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and the costs to which you have agreed in advance for preparing an explanation or summary. If we deny your request, in whole or in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other protected health information subject to your request.

We may in some circumstances deny your request without providing an opportunity for review, as when the information consists of psychotherapy notes or was compiled for use in a legal or administrative proceeding, or in certain other circumstances. There are other circumstances in which we must provide an opportunity for review of our denial, as when the denial is based upon a determination that provision of the information is likely to cause substantial harm to you or another person. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contract Officer identified in Section 7 of this Notice, if you believe our denial was improper.

- D. Amendments. You may request amendments to protected health information maintained about you in a designated record set. If we accept your request in whole or in part, we must identify the information affected thereby, provide a link to the amendment, and make reasonable efforts to notify within a reasonable time persons disclosed by you or known to us who might foreseeably rely on the information to your detriment. We may deny your request if we determine that the information subject to your request is already accurate and complete, is not part of the designated record set, would not be available for inspection as described in Paragraph 3.C above, was not created by us, and in certain other circumstances.

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link to the request, our denial, and any statements of disagreement and rebuttal. We will also be required if asked by you to include your request for amendment and our denial with any further disclosures of the information subject to your request. If you submit a statement of disagreement, we will be required to include your request for amendment, our denial, your statement of disagreement, and any rebuttal statement with any subsequent disclosure of the information to which the disagreement relates. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health

and Human Services or the Privacy Contact Office identified in Section 7 of this Notice, if you believe our denial was improper.

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

- F. Paper Copies of this Notice. Regardless of the form in which you have chosen to receive this Notice from us, you may receive a paper copy at any time from the Privacy Contact Officer identified in Section 7.

6. Changes to Privacy Practices.

We must change our privacy practices when required by changes in the law. We reserve the right to make other changes to our privacy practices or to this Notice that comply with the law. Whenever a change to our privacy practices materially affects the contents of this Notice, we will prepare a revised Notice and send it within 60 days to individuals then covered by the Plan. The Privacy Contact Officer identified in Section 7 will also provide a current copy of this Notice upon request. A change to our privacy practices that requires a revision of this Notice may not be implemented before the effective date of the revised Notice. However, we reserve the right to make the terms of any revised Notice effective for all protected health information that we maintain.

7. Additional Information and Complaints.

You may as specified below obtain additional information and/or submit complaints regarding our duties and your rights with respect to protected health information:

- A. Privacy Contact Person. The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy Contact Person, whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice. You can reach the Privacy Contact Person at the following phone and address:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions
Attn: Privacy Contact Person
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (206) 859-2600
Email: iaff-merp@vimly.com

- B. Privacy Complaints. You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Person or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.
- C. No Intimidation or Retaliation. No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a privacy Complaint.

8. Effective Date:

This Notice shall become effective on July 6, 2015, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section 6.

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

FROM:

BOARD OF TRUSTEES

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST

Privacy Contact Person phone number: (206) 859-2600