Plan Summary

March 2024

Welcome! You are an eligible participant in the **VEBA Plan**. Please carefully review this Plan Summary regarding your health reimbursement arrangement (HRA), and keep it in a safe place for future reference.

HRA Dashboard. The HRA Dashboard included with your welcome packet, which was mailed to you upon enrollment, contains important Plan and account information, your coverage type, claims-eligibility, and investment allocation. If you misplace your welcome packet, you can request a replacement copy from our Customer Care Center (see contact information below).

Investment Allocation. Your account is invested 100% in the VEBA **Conservative Portfolio** (default) until you make a change.

Online Registration. To help protect your privacy, you should register online and create a password. Go to **veba.org**, click the **Participant Login** button, and follow the instructions. After logging in, you can check and update your **investment allocation**, add your **spouse and dependent information**, request a free **debit card**, set up **direct deposit** (if claims eligible), and elect **e-statements**.

Mobile App. Managing and using your HRA has never been easier. After registering online, search and download our handy mobile app, **HRAgo®**, from the App Store or Google Play.

Submitting Claims. When you're ready to file a claim, log in at **veba.org** and click **Claims**, or use **HRAgo**. With **HRAgo**, you can quickly snap pics of supporting documentation and submit claims right from your mobile device. We'll process your claim in about five to seven business days.

Benefits Card. You can request and use our free debit card to pay medical expenses directly from your HRA. No filing claims and waiting to get reimbursed! Be sure to save all supporting documentation (insurance Explanations of Benefits (EOBs, itemized statements, etc.) in case we need copies.

Automatic Premium Reimbursements. We can automatically reimburse your monthly retiree insurance premiums, including Medicare. Log in at **veba.org** and click **Claims**. Then, click the **Set up an Automatic Premium Reimbursement** button and follow the instructions.

This Plan Summary explains how to use your VEBA Plan benefits and the rights and responsibilities of those covered by the Plan. You and all covered individuals should read and become familiar with its content. In the event of a discrepancy between this Plan Summary and the actual Plan and Trust documents, the Plan and Trust documents control. Other than the Plan and Trust documents, this Plan Summary supersedes any previously published Plan informational materials. This Plan Summary will be amended from time to time. For the most current version, log in at **veba.org** and click **Resources**, or contact our Customer Care Center (see contact information below).

Group health plans are required to furnish a standardized **Summary of Benefits and Coverage** (SBC) annually. The purpose of the SBC is to help consumers compare benefits across available insurance plans. While the VEBA Plan is a group health plan, it is not insurance. Therefore, certain information and defined terms in the SBC do not apply. This **Plan Summary** is your best source for detailed Plan information. If you need a copy of the SBC, log in at **veba.org** and click **Resources**. Printed copies are available upon request from our Customer Care Center (see contact information below).

Your employer may not have elected to include all of the benefits or plan features described in this Plan Summary. Your welcome packet confirms your benefits eligibility and any limitations. You can also find this information after logging in at **veba.org**.

The most current VEBA Plan Summary supersedes any previously published Plan informational materials. **By participating in the VEBA Plan, you agree to the Terms & Conditions set forth within Part X of this Plan Summary**.

CONTENTS

QUESTIONS?

Customer Care Center
PO Box 4389
Clinton, IA 52733-4389

1-888-828-4953

veba.org

SCAN WITH YOUR MOBILE DEVICE TO VIEW VIDEO LIBRARY ▶

Part I
Plan Information

This Trust is a voluntary employees' beneficiary association (VEBA) under Internal Revenue Code § 501(c)(9).

The mission of the VEBA Trust is to provide public employees tax-free health reimbursement arrangement (HRA) plans, compliant with regulatory requirements, efficient administration, prudent investments, and superb service.

The name of the Trust is: VOLUNTARY EMPLOYEES' BENEFIT ASSOCIATION TRUST FOR PUBLIC EMPLOYEES IN THE STATE OF WASHINGTON.

The identification number assigned to the Trust by the Internal Revenue Service is: 91-1214669.

The name of each Plan (collectively "VEBA Plan" or "Plan") is:

Covering K-12 school districts and community and technical colleges

- VEBA Standard HRA Plan
- VEBA Post-separation HRA Plan
- VEBA Limited HRA Plan

Covering higher education institutions and general state agencies

- VEBA MEP Post-separation HRA Plan
- VEBA MEP Limited HRA Plan

The plan year is the 12-month period from June 1 through July 31.

Each Plan's agent for service of legal process is: Russell Greenblatt, Katten Muchin Rosenman LLP, 525 West Monroe Street, Chicago, IL 60661-3693. Notice of legal process may also be delivered to a Trustee or the VEBA Plan at: 221 N Wall Street, Suite 201, Spokane, WA 99201.

The VEBA Plan is a welfare benefit plan that provides medical benefits only. This Plan does not provide retirement income. The medical reimbursement benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf. Accordingly, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

Eligibility and funding sources are usually defined in writing within plan documents, collective bargaining agreements, employer policies, or other similar documentation. Contact your employer, union, or employee group leadership if you have questions about your HRA participation or need a copy of the collective bargaining agreement or employer policy.

Plan Consultant. The Spokane, WA branch of Gallagher Benefit Services, Inc., manages the VEBA Plan's Customer Care Center in Spokane. In addition, Gallagher's field team provides local on-site service to employers. This includes technical support, plan adoption/renewal assistance, group presentations, etc. In addition, Gallagher provides specialized consulting services to the Board of Trustees and coordinates all VEBA Trust activities, including the services provided by other plan service providers.

Investments. Investment consulting is provided by The Hyas Group. The fund managers are: Goldman Sachs Asset Management; Fidelity; Metropolitan West Asset Management, LLC; The Vanguard Group, Inc.; Scout Investment, Inc.; Champlain Investment Partners, LLC; and American Funds.

Requests for benefits under the Plan must be made in writing in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing.

Board of Trustees and Plan Administrator. The Board of Trustees serves as the Administrator for the Plan. Trustees hold office until resignation, retirement, or removal. Replacement Trustees are appointed by the founding associations. The following are the current Trustees from each founding association:

Dr. Greg Baker, Chairman
WASA

Mathew Knott, Vice Chairman
WASBO

Shane Backlund, Secretary
WASA

Maria Breuder, Treasurer
AWSP

Cameron Grow
AWSP

Elaine Thompson
WASBO

Founding Associations

Association of Washington School Principals (AWSP)
1021 8th Ave SE, Olympia, WA 98501

Washington Association of School Administrators (WASA)
825 5th Ave SE, Olympia, WA 98501

Washington Association of School Business Officials (WASBO)
284 Lee St SW, Ste 132, Tumwater, WA 98501

Part II
Questions & Answers

What is the VEBA Plan? The VEBA Plan is a funded health reimbursement arrangement (HRA).

What is an HRA? An HRA or health reimbursement arrangement is a type of welfare benefit plan or group health plan. An HRA is generally funded by the employer (or through mandatory group funding) and reimburses employees (participants) for qualified out-of-pocket medical care expenses and insurance premiums incurred by the employee, the

employee's spouse, and qualified dependents. To understand who qualifies as a dependent, see **Part III** for our **Definition of Dependent** information.

What is a "funded" HRA? A funded HRA is designed so that your employer contributes funds into an individual account on your behalf. Common funding methods include unused leave cash-outs (annually, at separation, or retirement), mandatory employee contributions (group salary reduction), and direct employer contributions. Eligibility and funding sources, including any changes in funding, are usually defined in writing within collective bargaining agreements, employer policies, or similar documentation. Check with your employer, union, or employee group leadership if you have questions about what HRA funding sources may apply to you.

All contributions, investment earnings, and reimbursements (benefit payments) are tax-free. Contributions to your HRA are not subject to federal income tax or FICA tax. Investment earnings credited to your HRA are not subject to federal income tax.

Reimbursements paid out as qualified medical expenses on behalf of participants, spouses, and qualified dependents are also excluded from tax. HRA contributions will not be reported on IRS Form W-2 from your employer. You do not report HRA contributions, earnings, or benefit payments (reimbursements) on your individual IRS Form 1040 federal income tax return either.

What type(s) of benefits coverage do I have? Based upon current guidance issued under federal law, the VEBA Plan offers three different types of benefits coverage: **Standard HRA Plan, Post-separation HRA Plan,** and **Limited HRA Plan**. Each of these plan coverages is designed to be exempt from the annual and lifetime dollar-limit restrictions for group health plans. This means that your benefits under the Plan are limited by your account balance at the time you file any claim for reimbursement of qualified medical care expenses.

Some employers may establish and contribute funds on your behalf to more than one HRA, and each account may provide a different coverage type. Your **welcome packet** confirms your benefits coverage type at the time of enrollment. However, your coverage could change based upon restrictions under applicable law or coverage election changes that you make. You can always log in at **veba.org** to confirm your current benefits coverage for each account.

What is the Standard HRA Plan? The Standard HRA Plan is designed to be "integrated" with each employer's qualified group health plan that complies with certain requirements under federal law. Under the terms of the Standard HRA Plan document, a participant's HRA is considered integrated with the employer's qualified group health plan and eligible to receive employer contributions only if, at the time the participant becomes eligible for such contribution, the participant is eligible to enroll in his or her employer's qualified group health plan and either (a) is actually enrolled in or covered by the employer's qualified group health plan or (b) has provided written confirmation of enrollment in or coverage under another qualified group health plan. Read our **What is a Qualified Group Health Plan?** handout to learn more. To get a copy, log in at **veba.org** and click **Resources**, or contact our Customer Care Center (see front page)**.**

Please note that HRAs of participants who are offered coverage through the purchase of individual policies (as opposed to employer- sponsored group coverage) are not considered integrated with the employer's qualified group health plan and are not eligible to receive contributions to an account that allows Standard HRA Plan benefits.

What is the Post-separation HRA Plan? The Post-separation HRA Plan is designed to provide full benefits only after a participant separates from service or retires. However, depending on the employer, claims for the following types of qualified expenses and premiums may be reimbursed during employment: (1) dental; (2) vision; and (3) long-term care. Contributions are accepted into the Post-separation HRA Plan for any eligible employee, including those who are not eligible for contributions to the Standard HRA Plan. Post-separation (retiree-only) HRAs are not subject to the annual and lifetime limits restrictions and certain other provisions under federal law.

What is the Limited HRA Plan? The Limited HRA Plan is designed to provide limited forms of benefit coverage based upon plan design elections by your employer, restrictions governed by federal law, or certain elections made by you as further described below. For information about Limited HRA coverage based upon plan design or restrictions governed by federal law, read **Are there any restrictions?** below. For more information about Limited HRA coverage based upon elections made by you, read **What is Limited HRA coverage, and why might I need it?** below.

Where can I find the forms I will need for my HRA plan? All the HRA forms that you will need in order to file claims, change investment allocations, change personal information, and make other elections can be obtained by logging in at **veba.org** or upon request from our Customer Care Center (see front page).

When and how can I get money out of my HRA? For HRAs that allow Standard HRA Plan benefits, employees may file claims while they are currently employed (in-service), for expenses they incur after they are enrolled. HRAs limited to Post-separation HRA Plan benefits require employees to separate from service or retire before becoming eligible to file claims for expenses incurred after separation from service.

You can confirm your claims eligibility by referencing your **welcome packet** or by logging in at **veba.org**. If you are not immediately eligible to file claims, you will be notified when you do become eligible. After becoming claims-eligible, and depending on the eligibility terms of your HRA, you may begin filing claims for qualified out-of- pocket medical care expenses incurred by you, your spouse, and any qualified dependents.

You may file claims for any amount, but reimbursements are limited to your available HRA balance. Eligible benefits will be paid until your HRA is exhausted. Your employer's plan design,

IRS rules, or certain elections made by you may limit dependent coverage, as well as when and what expenses may be reimbursed.

Claims payment is efficient and hassle-free. You can submit claims, sign up for direct deposit, or set up automatic reimbursement of recurring qualified insurance premiums after logging in at **veba.org**. If you prefer, you can use paper forms instead. Paper forms are available after logging in at **veba.org** or upon request from our Customer Care Center (see front page).

What expenses are eligible for reimbursement? Eligible expenses generally include qualified medical, dental, and vision expenses (not covered by your insurance plans) and premiums for medical, dental, or vision, insurance or for Medicare premiums and expenses, and tax-qualified long-term care insurance. Eligible expenses are defined in Internal Revenue Code § 213(d). For a list of common qualified expenses and premiums, read our **Medical Care Expenses** handout available after logging in at **veba.org** or upon request from our Customer Care Center (see front page).

IRS regulations provide that insurance premiums may not be reimbursed by your Plan if they are (1) paid by an employer, (2) eligible to be deducted through your employer's Section 125 cafeteria plan, or (3) subsidized by the Premium Tax Credit (subsidy). When requesting reimbursement of premiums deducted from your paycheck after tax, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available to you. Qualified premiums deducted from your spouse's paycheck after tax are eligible for reimbursement regardless of whether a pre-tax option exists for your spouse.

Qualified expenses that may be reimbursed from your HRA for you and your dependents will depend on the applicable plan design, IRS rules, or certain elections you may make to limit your HRA coverage. For example, some plan designs limit reimbursements to qualified insurance premiums only. Under certain circumstances (discussed later in this Section), expenses for your spouse and dependents may be limited based upon rules imposed under federal law. Also, if you have elected Limited HRA coverage (discussed later in this Section), the types of expenses eligible for reimbursement are limited.

Are there any restrictions? Reimbursements (claims) may never exceed your available account balance at the time you file the claim. Depending on the applicable plan design, your account may be limited to Post-separation HRA Plan coverage. Also, some employers limit reimbursements to qualified insurance premiums only. Some employers may establish and contribute funds on your behalf to more than one type of HRA, and each account may be subject to different limitations as further described in this Section. Your **welcome packet** confirms your benefits eligibility and any restrictions on your account. You may also log in at **veba.org** to confirm whether your Plan has any limitations on reimbursable expenses.

If your employer has established an HRA for you that is limited to Post-separation HRA Plan coverage, IRS rules require that your claims eligibility be limited to reimbursement of expenses and premiums for dental, vision, and qualified long-term care ("Excepted Benefits") during any period that you are subsequently re-employed with the employer that made contributions to your HRA.

If you have the Standard HRA Plan (meaning your account permits In-service Benefits coverage), spouse and dependent integration rules issued under federal law will apply. This means that certain expenses for your spouse and dependents may not be reimbursable while you are employed, unless your spouse and dependents are covered under a group health plan (GHP) at the time the expense is incurred. The spouse and dependent integration rules **only** apply if you are still working for the employer who contributed to your account.

You can confirm GHP coverage for your spouse or dependent(s) on your claim form when you submit a claim. If your spouse or dependent(s) are not covered by a GHP, you can still use your HRA to reimburse you for their dental expenses and premiums, vision expenses and premiums, and tax-qualified long-term care expenses and premiums.

How do I use my Benefits Card? Your Benefits Card can be used instantly to pay medical care expenses directly from your health reimbursement arrangement (HRA). Be sure to save your supporting documentation, as the IRS requires us to make sure every transaction is for a qualified medical expense. Sometimes the electronic transaction data we receive from the merchant is not enough. We will let you know when we need additional details like an explanation of benefits (EOB) or detailed invoice from your medical provider. For more details about your Benefits Card, visit the Resources tab for the Benefits Card FAQ and other information after logging in to your account at **veba.org** or upon request from the Customer Care Center.

SCAN WITH YOUR MOBILE DEVICE TO VIEW USING BENEFITS CARD VIDEO ▶

How can I get a Benefits Card? You can request a Benefits Card at any time by contacting the Customer Care Center or logging into your online account. You must have at least $50 in your account and a valid U.S. mailing address on file with the Plan.

Are there any limits or restrictions on my Benefits Card? You must keep an account balance of at least $50 in your HRA or your card will not work. Additionally, you can spend up to 90% of your HRA balance every day (subject to a $5,000 daily limit).

What do I do if my Benefits Card transaction is declined or denied? A **declined** transaction is when the swipe at the merchant does not go through and your HRA account balance is not [charged/debited] for the transaction. A Benefits Card transaction may be declined by the merchant for a variety of reasons, including (1) that the merchant is not an approved medical care provider; (2) your account balance is insufficient; or (3) you are attempting to purchase items that are not approved as medical expenses. A **denied** transaction is when the debit card swipe has been approved at the merchant and

your HRA account balance has been reduced. However, the Plan is denying the transaction for some reason, most likely because additional supporting documentation is required or the documentation you provided is insufficient. Note that neither a declined transaction nor a denied transaction is considered a claim for purposes of filing an appeal under Part IV regarding Procedure for Disputed Claims. In order to initiate the appeals process for a transaction that originated as a Benefits Card swipe, you must first file a claim for reimbursement of the expense.

What happens if I don't provide documentation when you ask me for it? Most of your Benefits Card transactions will be approved at the point of sale. In some cases though, the Plan will need additional documentation to verify the expense. IRS rules require the Plan to follow prescribed "pay-and-chase" rules if a participant does not submit sufficient documentation in these cases. Eventually, this may mean that we have to suspend your card, but don't worry! We'll give you plenty of time before that happens. The Plan will follow its applicable "pay-and-chase" rules, which may include, but are not limited to requesting that you reimburse the Plan for the amount that has not been verified, offsetting future reimbursement of claims by the amount not verified, and suspending your card. In some cases, the IRS requires the plan to report the unverified amount as taxable income.

SCAN WITH YOUR MOBILE DEVICE TO VIEW SUPPORTING DOCS VIDEO ▶

Can my HRA automatically reimburse my insurance premiums? Yes. Simply submit a completed and signed **Automatic Premium Reimbursement** form with proper documentation. Based on your instructions, the Plan will reimburse insurance premiums from your account on an automatic basis. Direct deposit of reimbursements is available and recommended.

SCAN WITH YOUR MOBILE DEVICE TO VIEW AUTOMATIC PREMIUMS VIDEO ▶

What happens if my claim for reimbursement is denied or paid in error? If your claim for reimbursement of expenses is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims are discussed in Part IV of this document.

If after receiving a reimbursement it is later determined that you, your spouse, or a qualified dependent received a payment in error, federal regulations require that you repay the overpayment or erroneous reimbursement back to your VEBA Plan. If you do not repay the overpayment or erroneous payment, the VEBA Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment against your account.

What is a health savings account (HSA), and can I contribute to an HSA? An HSA is a type of tax-favored medical reimbursement account that differs from an HRA. Your VEBA Plan is an HRA, not an HSA. If you want to make contributions to an HSA, you must meet the HSA contribution eligibility requirements. HSA eligibility requirements are contained in IRS Publication 969 at www.irs.gov or www.ustreas.gov.

Can I have both an HRA and an HSA? Yes, you can have an HRA and an HSA, though certain rules apply. You can use either your HRA (if claims-eligible) or HSA to reimburse your qualified expenses. There are no ordering rules regarding which account must pay first, but note that most of your premiums incurred prior to age 65 are not reimbursable under an HSA. Also, if you have a claims-eligible HRA, current IRS rules require that you limit that HRA coverage temporarily if you want to make or receive contributions to an HSA.

To limit your HRA account, simply submit a **Limited HRA Coverage Election** form. You can get a copy online after logging into your account, or from the Customer Care Center (see front page).

Keep in mind that limiting your HRA account is not the only HSA contribution eligibility requirement.

What is Limited HRA coverage, and why might I need it? Limited HRA coverage is an election that limits the types of expenses and premiums that are eligible for reimbursement from your HRA. If your HRA is fully claims eligible, you may want or need to limit your VEBA Plan if: (1) you are a current employee and you, your spouse, or a dependent have Medicare coverage that you want to be primary to your HRA coverage; (2) you, your spouse, or a dependent would like to be eligible to make or receive contributions to a health savings account (HSA); or (3) you, your spouse, or a dependent want to become eligible to receive a Premium Tax Credit (subsidy) through a marketplace exchange.

HSA Coordination. IRS rules allow you to have an HRA and an HSA, though certain restrictions apply. If you are claims-eligible, you can use either your HRA or HSA to reimburse your qualified expenses (there are no ordering rules regarding which account must pay first). However, if you have a claims-eligible HRA, current IRS rules require that you limit that HRA coverage if you want to make or receive contributions to an HSA. Keep in mind that limiting your HRA is not the only HSA contribution eligibility requirement. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for HSA coordination purposes: dental (including orthodontia); qualified high-deductible health plan (HDHP) premiums; and vision.

Medicare Coordination. If you have a claims-eligible HRA and are still working for your contributing employer, Medicare Coordination of Benefits rules may require your HRA pay first. If you are retired or separated from your HRA contributing employer, the Medicare Coordination of Benefits rules will **not** apply to your HRA. Read Part VII for more information about your VEBA Plan and Medicare. If Medicare Coordination of Benefits rules do apply to your HRA, you may limit your HRA until you separate from service so that Medicare instead pays first. Only the

following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Medicare coordination purposes: dental (including orthodontia); vision; and Medicare and Medicare supplement premiums.

Premium Tax Credit Eligibility. For any month that you are claims-eligible and have a positive account balance in your HRA, you may not qualify for the Premium Tax Credit (subsidy) unless you take certain action. Please refer to Part VI for more information. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Premium Tax Credit eligibility purposes: dental (including orthodontia); qualified long-term care (subject to IRS limits); and vision.

To elect Limited HRA coverage, simply submit a completed **Limited HRA Coverage Election** form. Forms are available online after logging in at **veba.org** or upon request from our Customer Care Center (see front page).

SCAN WITH YOUR MOBILE DEVICE TO VIEW HRA COORDINATION VIDEO ▶

What happens if I get divorced? In the event that you become divorced or legally separated, your account may be split as part of a divorce decree, court order, or similar agreement. Coverage for an ex-spouse is taxable. Contact the Customer Care Center for more information.

What if I pass away before using up my HRA? If you pass away, your HRA would be transferred to a new account in the name of your surviving spouse. All of your other dependents, if any, would remain eligible for coverage. This new account could also be used to reimburse qualified medical care expenses incurred by you prior to your passing.

After your spouse passes away, or if you have no spouse, any remaining portion of your HRA may be transferred equally (and only once) to your survivors in the following order: (1) dependents and non-dependent (adult) children; (2) designated beneficiaries; or (3) other survivors. If your account is split between two or more survivors and one passes away, any remaining funds in that account would be reallocated equally among the remaining survivor(s).

For more details, read our **What Happens If I Pass Away?** brochure. To get a copy, log in at **veba.org** and click **Resources** on the menu bar.

Can my HRA funds ever be forfeited? Yes, but forfeiture circumstances are rare. First, forfeitures occur in the unlikely event a deceased participant: (1) is left with remaining funds after all final claims have been paid; and (2) has no surviving spouse, dependents, non-dependent (adult) children, designated beneficiaries, or other eligible survivors to whom the account could be transferred.

Second, abandoned accounts may be forfeited. This would apply if, during a period equal to the lessor of the applicable unclaimed property period or three years: (1) at least two communications from the Plan to the participant have been returned as undeliverable; (2) there have been no contributions to or reimbursements (claims) from the participant account; and (3) no communications or other expressions of interest have been received from or on behalf of the participant. It is very important that you keep your contact information current with the Plan to avoid this type of forfeiture.

For K-12 and community and technical college participants, forfeited funds may be reallocated to remaining participants or used to offset future contributions as directed by the employer. For state agency and higher education participants, forfeited funds are automatically reallocated to remaining participants.

How are my HRA funds invested? You may invest your HRA using any combination of the available investment funds. You may change your investment allocations as often as once per calendar month after logging in at **veba.org** or by calling our Customer Care Center (see front page).

An **Investment Fund Overview** with investment performance history and fund objectives is updated quarterly and available after logging in to at **veba.org**. In addition, you may view and should read the up-to-date fund fact sheets and prospectuses on the fund websites, which are listed on the Investment Fund Overview.

Will I receive a statement of my account? Yes. Participant account statements, which detail all of your account activity, are updated quarterly and available for viewing online after logging in at **veba.org**. If you are signed up for e-communication, you will receive quarterly email notifications as soon as your statements are available for online viewing. If you are not signed up for e-communication, paper statements will be mailed semi-annually (in January and July) to your mailing address on file. You may contact our Customer Care Center (see front page) to request copies of your statements at any time.

What should I do if I believe there is an error on my statement?
If you believe there is an error on your account or in your statement, you must contact the Customer Care Center to immediately report the error. All errors must be reported within ninety (90) days from the date the potential error is (a) viewed through your online portal; or (b) viewable on an account statement. The Plan will follow its applicable rules regarding the notification of errors and perform a timely investigation of any error notifications. You will be notified of the results of that investigation and any applicable resolution that may be taken.

Can I view my account information online? Yes. You may view your personal account information online after logging in at **veba.org**. Information available online includes account details and preferences, investment performance, contribution and claims history, and participant forms. You can also set up an automatic premium reimbursement, update account preferences, and update your personal information (name, address, etc.).

Are any fees or expenses deducted from my HRA? Yes. Plan administrative expenses include claims processing,

customer service, account administration, printing, postage, legal fees, consulting fees, local servicing, auditing, search services, etc. To cover these costs, a month per-participant fee of $1.50 (if claims eligible) or $0.75 (if not claims eligible), plus an annualized asset-based fee of about 1.00%, is charged to your account. The monthly fee is waived if your account balance is more than $5,000. In addition, a 0.25% asset-based fee discount applies to any portion of your account balance in excess of $10,000. If you have more than one account, the balances in each account are combined when determining your eligibility for waived or discounted fees. Your account value changes daily based on activity, which includes investment earnings/losses, contribution and claims activity, and assessment of the asset-based fee.

Investment fund manager fees and other fund expenses are based on the investment fund(s) you select. To view these fees, refer to the quarterly **Investment Fund Overview**, which is available online after logging in at **veba.org** and clicking **Resources**

Is there a custodian or transfer agent for the Plan? Washington Trust Bank is the custodian/ transfer agent for the Plan to hold title to assets on behalf of the Plan, execute investment trades as requested, and perform periodic valuations of the Plan's assets.

Who is responsible for developing and managing the VEBA Plan? The VEBA Plan is offered by the non-profit VEBA Trust, which is managed by a Board of Trustees appointed by the founding associations. The Board of Trustees serves as the Administrator for your Plan.

The VEBA Plan is administered according to information supplied by your employer, in accordance with the VEBA Trust's and Plan's official governing documents, policies and procedures established by the Board of Trustees, and applicable law. Your employer's policies and procedures may affect plan design and administration at the employer level. The VEBA Plan is responsible only for adhering to its official governing documents, policies, procedures, and applicable law.

An audit of the Trust's financial records is conducted annually by an independent certified public accounting firm. The audit does not verify the accuracy of contribution amounts calculated and contributed by your employer. Responsibility for such verification lies between you and your employer.

What about amendments or termination of the VEBA Plan? Although the Trustees currently intend to continue the VEBA Trust and Plan indefinitely, the Trustees reserve the right to amend or discontinue offering the VEBA Trust or Plan. The Trustees amend the official VEBA Trust and Plan documents when necessary to remain compliant with applicable tax law changes and IRS rules and guidelines.

How do I find out more about the Plan? Visit **veba.org** to learn more about the VEBA Plan. If you have a current HRA account and would like more information, please contact the Customer Care Center at 1-888-828-4953**.**

Will the Plan always be available? Your employer retains the right to discontinue the Plan subject to the provisions of collective bargaining (if applicable), and in accordance with the terms of the Trust. If the Plan were to be discontinued, Plan assets would be treated in accordance with the terms of the Plan document and the terms of the Trust.

Part III
Definition of Dependent

Your spouse and dependents are eligible for coverage under your health reimbursement arrangement (HRA). Dependents must meet the definition of Qualifying Child or Qualifying Relative. These requirements are defined by Internal Revenue Code Sections 105(b) and 152.

A **Qualifying Child** is someone who: (1) is the participant's son or daughter, stepchild, foster child; and is a citizen, national, or resident of the United States or a resident of Canada or Mexico; and is either (a) age 26 or younger at the end of the calendar year in which expenses were incurred, or (b) permanently and totally disabled; or (2) is a brother, sister, stepbrother, stepsister, or a descendant of the participant's son, daughter, stepchild, or foster child; and is either (a) under age 19, or (b) under age 24 and a full-time student, or (c) permanently and totally disabled; and is younger than the participant; and lives with the participant for more than half the year; and does not provide more than half of his or her own support; and will not file a joint tax return for the year in which the expense was incurred; and is a citizen, national, or resident of the United States or a resident of Canada or Mexico.

A **Qualifying Relative** is someone who: (1) is the participant's (a) son, daughter, stepchild, foster child, or a descendant of any of them (e.g. a grandchild); or (b) brother, sister, or a son or daughter of either of them; or (c) father, mother, or an ancestor or sibling of either of them (e.g. the participant's grandmother, grandfather, aunt, or uncle); or (d) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-aw, or sister-in-law; or (e) any other person (other than the participant's spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and (2) will not be a Qualifying Child or any other person as of the last day of the calendar year in which expenses were incurred; and (3) for whom the participant provided over half the support for the calendar year; and (4) is a citizen, national, or resident of the United States or a resident of Canada or Mexico.

Qualifying Child of Divorced or Separated Parents. A participant's child is treated as the dependent of both parents for the purposes of health plan coverage if during the calendar year in which expenses were incurred: (1) the participant's child is in the custody of the participant or their other parent for more than half the year; (2) the participant's child receives over half of his or her support during the year from the participant or their other parent.

Domestic Partners. Unless your domestic partner qualifies as a legal spouse under state law, a domestic partner must meet all of the **Qualifying Relative** requirements to be eligible for coverage under your HRA. If you need to list your domestic partner as a dependent, please give us a call.

Part IV
Procedure for Disputed Claims

The following is an overview of how you may dispute denied claims.

If you have a question or complaint regarding how one of your claims was adjudicated, please reach out to our Customer Care Center (see front page). A Customer Service Representative will be happy to look into your claim and address your questions or concerns. Our Customer Care Center is often able to help resolve the matter and alleviate any frustrations.

When must I receive a decision on my claim? You are entitled to notification of the decision on your claim within 30 days after the Plan's receipt of the claim. The 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Plan. The Plan is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Plan will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you submit the additional information, the Plan will notify you of the decision on your claim within 15 days after the date of receipt of such information. If you do not submit the additional information, the claim will be deemed to be denied immediately following such 45-day period. The notice from the Plan requesting additional information may also contain a provisional denial of the claim in the event the additional information is not received within the 45-day period.

What information will a notice of denial of a claim contain? If your claim is denied, the notice that you receive from the Plan will include the following information: (1) the specific reason or reasons for the denial and sufficient information to identify the claim involved, if any, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) specific references to pertinent plan provisions or IRS rules and regulations on which the denial is based; (3) an explanation of your right to appeal the denial; (4) a description of any additional material or information necessary for you to perfect the claim or appeal the denial and an explanation of why such material or information is necessary; (5) an explanation of your right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process; (6) a description of available internal appeals procedures, including information regarding how to request an internal review of your denial and the time frame within which to submit such a request; and (7) an explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

If you do not receive an approval or denial of your claim within the initial time period for review of your claim, your claim will be deemed to have been denied.

Do I have the right to appeal a denied claim? Yes, you have the right to an internal appeal and, if applicable, an external review by an independent review organization.

Do I have to appeal a denied claim before I can go to court? You will not be allowed to take legal action against the Plan, your employer, the administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit, and a final external review decision does not prevent you from pursuing other state or federal law remedies if they are available.

Is there a deadline for requesting my internal appeal? Yes. Your internal appeal must be delivered to the Plan within 180 days from the date you receive notice that your claim was denied or from the date your claim was deemed to be denied. If you do not file your internal appeal within this 180-day period, you lose your right to appeal.

How will my internal appeal be reviewed? Any time before the deadline to request an internal appeal, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Plan. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Plan will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Plan relies on, generates, or considers new or additional evidence in connection with its final internal adverse benefit determination, other than evidence that you have provided to it, you will be provided with this information within 30 days after the date the Plan received your request for internal appeal, and given a reasonable opportunity (15 days) to respond to the evidence or rationale before the due date for the Plan's internal review decision. If you do not respond to the new or additional evidence or rationale considered in denying your claim within the time period permitted to respond, your claim will be deemed to have received a final internal adverse benefit determination immediately following such time period. The notice from the Plan with such additional evidence or rationale may also contain a provisional final internal adverse claim determination in the event the additional information is not received within the specified time period.

The internal appeal determination will be conducted by someone who is not (1) the individual who made the original

determination; or (2) an individual who is a subordinate of the individual who made the initial determination.

When will I be notified of the decision on my internal appeal? The Plan must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

What information is included in the notice of the denial of my internal appeal? If you receive a final internal adverse benefit determination, the notice that you receive from the Plan will include the following information: (1) the specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) specific references to the pertinent plan provisions or IRS rules and regulations on which the decision is based; (3) a description of available external review procedures, including information regarding how to request an external review of the internal appeals decision and the time frame within which to submit such a request; and (4) the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist you with the external review procedures.

If you do not receive an approval or denial of your appeal within the initial time period for review of your appeal, your appeal will be deemed to have received a final internal adverse benefit determination subject to external review.

Do I have the right to seek a review of a final internal adverse claim determination to an external third party? You have the right to an external review of the Plan's denial of your internal appeal, unless the denial was based on your (or your spouse's or dependent's) failure to meet the Plan's eligibility requirements.

Is there a deadline for filing my request for external review? Yes. You must file your request for external review not later than the first day of the fifth month after you received notice from the Plan of, or are deemed to receive, a final internal adverse benefit determination. If you do not file your request for external review within this period, you lose your right to external appeal. For example, if you received or are deemed to receive your final internal adverse benefit determination on January 3 of any year, you must request external review by June 1 of the same year (or, if that is not a business day, the next business day thereafter).

What is the process for my external appeal? Within five business days after receiving the external review request, the Plan must complete a preliminary review to determine if: (1) you are covered under the Plan; (2) you provided all the information and forms necessary to process the external review; (3) you followed and exhausted the internal appeals procedures; and (4) the denial of your claim related to you (or your spouse or dependent) not meeting the eligibility requirements under the Plan, as claim denials based upon a failure to meet eligibility requirements are not subject to external review.

Within one business day after completion of its preliminary review, the Plan will provide you with written notice of the outcome of its review. If your request for external review is complete but the claim denial is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and you will be permitted to complete the request not later than the deadline for filing a request for external review, or 48 hours after your receipt of the Plan's preliminary review notice, whichever is later.

If the Plan receives a timely, completed, and eligible request for external review, the Plan will assign an independent review organization (IRO) to review the claim and you will receive written notice from the IRO that your request is eligible for external review and has been assigned to such IRO.

You will have the right to submit additional information in writing to the IRO within 10 business days after the date you receive notice from the IRO and, if the IRO receives any additional information within 10 business days after you receive such notice, then (1) the IRO must consider the additional information in its external review, and (2) the IRO is required to forward the additional information submitted by you to the Plan within one business day after the date the IRO receives the information.

Within five business days after the date the IRO receives the external review assignment, the Plan is required to provide the IRO with all documents and information considered by the Plan in making its decision to deny the claim and internal appeal.

Upon receiving from the IRO any additional information submitted by you, the Plan may reconsider its previous decision. If the Plan reverses its decision upon such review, it will notify you and the IRO within one business day after making its reversal, and the IRO must terminate its external review. The IRO is not bound by the prior decision of the Plan in making its external review decision.

When will I be notified of the decision on my external appeal? The external reviewer must notify you and the Plan of its decision on your external appeal within 45 days after its receipt of your request for external review.

What information will be included in the IRO's decision on my external appeal? The notice to you of the IRO's external appeal decision will include the following information: (1) a general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial; (2) the date the IRO received the assignment to conduct the external review, and the date of the IRO's decision; (3) references to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards; (4) a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and

any evidence-based standards relied on in making the decision; (5) a statement that the IRO's decision is binding, unless other remedies are available to you or the Plan under state or federal law; (6) a statement that judicial review may be available to you; and (7) a phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Is the external reviewer's decision binding? The external reviewer's decision is binding upon the parties but does not terminate or preempt your right or the Plan's right to pursue other state or federal law remedies. However, such remedies may or may not exist. Therefore, unless another legal right exists for your claim, the external reviewer's decision will be binding.

Part V
Choosing Your Investment Allocation

The **HRA Dashboard** included with your welcome packet confirms your initial investment allocation. Until you make a change, the default is a 100% allocation to the VEBA Conservative Portfolio.

Investment Options. You get to choose how your HRA is invested. With **Option A: Choose a Pre-mix**, you can pick a pre-mixed asset allocation portfolio designed and managed by professionals. Many investment advisors recommend using pre-mixed portfolios. If you're comfortable making investment decisions and would rather build your own portfolio, you can pick just one fund or any combination of two or more funds under **Option B: Do It Yourself**.

Before making an investment decision, you should carefully consider target risk levels, time horizons, objectives, and fees. This and other important information is contained in the prospectus for each pre-mixed portfolio or individual fund, which you should read. For links to prospectuses, fact sheets, and historical performance, go to **veba.org** and click **Investments**.

Contributions and Withdrawals (claims). HRA contributions or transfers are deposited according to your asset allocation percentages on file. Withdrawals (claims) are deducted pro rata based on your investment holdings at the time of claim.

Investment Risk. Portfolio/fund values fluctuate on a daily basis. Withdrawals (claims) may be worth more or less than your original investment. Any investment that contains stocks or bonds entails the risk of loss. Investment returns, particularly over shorter time horizons, are highly dependent on investment market trends. Investing in stocks and bonds is suitable primarily as a longer-term strategy and should be considered carefully if you plan to file claims. Generally, investments with higher potential returns involve greater risk and more volatility. Past performance does not guarantee future results. Funds are not FDIC insured, are not guaranteed by a bank, and may lose value.

Periodic Review. You should review your investments at least once per year. As your circumstances change, you should reconsider your asset allocation strategy and make appropriate changes. This helps make sure your investment choices remain aligned with your current investment goals and time horizons.

Allocation Changes. If you need to change your investment allocation, log in at **veba.org** and click **Investments**. Changes are allowed once per calendar month. Allocation changes become effective and visible online within two to three business days after receipt.

Investment Advice. You're encouraged to seek advice from a personal financial advisor before making investment decisions. The Plan service providers and Customer Care Center do not give investment advice.

Fund Operating Expenses. Fund operating expenses are deducted from fund assets and include management fees, distribution (12b-1) fees, and other expenses.

More Information. More information can be found in our **Choosing Your Investment Allocation** brochure and **Investment Fund Overview** (updated quarterly) at **veba.org**.

Part VI
Premium Tax Credit (Subsidy) and Your HRA

You may qualify for the Premium Tax Credit (subsidy) if you or a family member purchase health insurance through a state or federal marketplace exchange (sometimes referred to as "Obamacare"). The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through an exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your out-of-pocket premium amount, or you can wait until you file your tax return.

Please note the following if you purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit: (1) Marketplace exchange premiums that are not subsidized by the Premium Tax Credit can be reimbursed from a full-coverage HRA; (2) Marketplace exchange premiums that are subsidized by the Premium Tax Credit cannot be reimbursed from your HRA; and (3) You may not qualify for the Premium Tax Credit for any month during which you have a full-coverage HRA. If you have a full-coverage HRA, are claims-eligible, and have a positive HRA balance or are receiving ongoing HRA contributions, then it may make sense for you to either use up or limit your HRA, as described in more detail below. If you decide to take one of these actions, you should do so before taking the Premium Tax Credit in advance.

Keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you cannot qualify for the Premium Tax Credit and you do not need to use up or limit your HRA: (1) You are eligible for employer-sponsored group

health plan coverage that meets the affordability and minimum value requirements under federal healthcare reform law. (If you are not sure whether this applies to you, check with your employer.); (2) You are eligible for coverage under a governmental plan such as Medicaid, Medicare, CHIP, or TRICARE; (3) Your total family income, including income from investments, retirement benefits, and Social Security, exceeds the maximum amount for eligibility for the Premium Tax Credit (400% of the federal poverty level); (4) You are married but do not file a joint tax return; or (5) You are claimed as a dependent on someone else's tax return.

What if my full-coverage HRA is the only thing keeping me from qualifying for the Premium Tax Credit? If you are claims-eligible and your full-coverage HRA is the only reason you cannot qualify for the Premium Tax Credit, you may consider one of these two options**: (1) Using up your HRA before taking the Premium Tax Credit**. You do not have to take the Premium Tax Credit right away. You could first use up your HRA to reimburse your non-subsidized premiums (and any other qualified medical care expenses incurred since your claims-eligibility date). Then, you could begin taking the Premium Tax Credit in advance to lower your monthly premium, or wait and claim it on your tax return, but only for premiums you paid after using up your HRA. Keep in mind that, if you receive any additional HRA contributions after using up your balance, you will lose eligibility for the Premium Tax Credit for any months during which you have (or had) a positive balance in your HRA. **(2) Electing Limited HRA coverage**. If you elect Limited HRA coverage, your HRA will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations). If you elect Limited HRA coverage for Premium Tax Credit eligibility, you can switch your HRA back to full coverage for any period that you are not taking the Premium Tax Credit. Limited HRA coverage is designed as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal healthcare reform law. To elect Limited HRA coverage, submit a **Limited HRA Coverage Election** form. Forms are available after logging in at **veba.org** and clicking **Resources**, or contact our Customer Care Center (see front page).

Consider your options carefully. You should seek advice from a tax professional. The best decision may vary depending on your individual circumstances, including the amount in your HRA compared to the subsidy amount you could receive. Keep in mind that if you take the Premium Tax Credit without first using up or limiting your HRA as described above, you will likely not qualify for the Premium Tax Credit and may be required to pay it back when you file your tax return.

Where can I get more information? This Plan Summary is intended to provide you with general information about the Premium Tax Credit and the options available to you under the Plan. For more information, go to www.irs.gov and type "Premium Tax Credit" in the search bar.

Part VII
Coordination of Benefits with Medicare and MMSEA Section 111 Reporting

If you're entitled to Medicare and your HRA is [fully] claims eligible, federal law governs whether your HRA or Medicare should be the first to reimburse or pay your medical expenses. The following summarizes the priority of claims payment as between your HRA account and Medicare unless you have elected Limited HRA coverage. For more information about electing Limited HRA coverage, refer to Part II of this Plan Summary.

To comply with federal law, you should file your claims in accordance with these primary and secondary payer rules if you have a claims-eligible HRA and have not elected Limited HRA coverage: (1) If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (2) If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (3) If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires the Plan to report specific information about your HRA to the Centers for Medicare and Medicaid Services (CMS), unless you have elected Limited HRA coverage or certain other exceptions apply. For more information about electing Limited HRA coverage, refer to Part II of this Plan Summary.

To comply with this federal law, the Plan requires you to provide information necessary to comply with the MMSEA Section 111 reporting requirements when you file a claim to your HRA. In addition, when submitting claims for reimbursement or coverage under your HRA and/or Medicare, you should follow the primary and secondary payer rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should reimburse or pay first, contact our Customer Care Center (see front page) or call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

Part VIII
Regulatory Compliance; Required Notices

VEBA Plan complies with the following requirements and does not discriminate with regard to a participant's health status, genetic information, age, disability, gender, race, or religious beliefs: Genetic Information Nondiscrimination Act (GINA); Age Discrimination in Employment Act (ADEA); Americans with Disabilities Act (ADA); Title VII of the Civil Rights Act and the Pregnancy Discrimination Act (PDA); HIPAA portability, privacy, and security requirements; Mental Health Parity Act (MHPA); and Mental Health Parity and Addiction Equity Act (MHPAEA).

Eligible expenses for the VEBA Plan are defined in Internal Revenue Code § 213(d), but benefits may be limited by your HRA coverage or account balance.

COBRA NOTICE: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides eligible participants and those covered by this plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered dependents should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to our Customer Care Center (see front page).

General Information. A qualifying event is an event resulting in the loss of continued employer contributions and/ or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as qualified beneficiaries. Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or qualified beneficiary is required to notify the Plan within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage.

Qualifying Events. If you are a **participating employee**, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you experience a reduction in hours affecting eligibility. If you are the **spouse** of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) you become divorced or legally separated from employee; or (4) employee passes away. **Qualified dependents** of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) employee and spouse become divorced or legally separated; (4) child reaches age limitation or no longer meets the definition of qualifying child; or (5) employee passes away.

Qualifying Event Notification. The Plan will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits. When the qualifying event is due to an active participating employee's voluntary or involuntary termination (other than for gross misconduct), reduction of hours of employment affecting eligibility, or death, the employer must notify the Plan within 30 days of the occurrence of such event. All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the Plan within 60 days of the occurrence of such event, using the **COBRA Event Notice** form. The Notice must be mailed or hand delivered to the Plan, and is available upon request from the Customer Care Center (see front page). A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation and additional documentation may be required. If the Notice is late, incomplete, or is not submitted as outlined in the Notice of Procedures provided on the aforementioned form, no qualified beneficiary may be offered the opportunity to elect COBRA coverage.

COBRA Continuation Period. The COBRA continuation period is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA. COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's voluntary or involuntary termination (other than for gross misconduct) or reduction of hours of employment affecting eligibility. A maximum of up to 36 months is allowed when the qualifying event is due to a participating employee's legal separation or divorce, death, or when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA Continuation Period Extension. If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the Plan within 60 days of the disability determination and before the end of the original

18-month COBRA continuation period. Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of a qualifying child), or death, the covered spouse and/or covered dependents may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the Plan within 60 days of the occurrence of the second qualifying event.

Information Resources. Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to our Customer Care Center (see front page), or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

MEDICARE PART D NOTICE OF NON-CREDITABLE COVERAGE: For participants, spouses, and dependents eligible or becoming eligible for Medicare, this required notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006. You may have heard about Medicare's prescription drug coverage (Medicare Part D) and wondered how it affects you. All Medicare Part D plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare Part D. Prescription drug coverage provided by this Plan is limited to your available HRA balance and is considered non-creditable. In other words, coverage provided by this Plan is, on average for all participants, NOT expected to pay out as much as the standard Medicare Part D coverage will pay.

If you don't enroll when first eligible, you may pay more and have to wait to enroll. Generally, individuals can enroll in Medicare Part D when they first become eligible for Medicare and each year during the Medicare open enrollment period (October 15 through December 7). If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your Medicare Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium for as long as you have Medicare Part D coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, or qualified dependents are currently Medicare eligible, you need to make a decision. The terms of this Plan will not change if you choose to enroll in Medicare Part D. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under your Medicare Part D plan, subject to the terms of this Plan and limited to your available HRA balance. You should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

More Information. Read the Medicare & You handbook from Medicare available online at **medicare.gov**. You can also: (1) Visit **medicare.gov** for personalized help; (2) Call your State Health Insurance Assistance Program (refer to the Medicare & You handbook for telephone numbers); or (3) Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also be contacted directly by Medicare-approved prescription drug plans.

For people with limited income and resources, extra help paying for a Medicare Part D plan is available. Find out more by visiting the Social Security Administration online at **socialsecurity.gov**, or by calling 1-800-772-1213. TTY users should call 1-800-325-0778.

You might receive this notice at other times in the future such as before the next period you can enroll in Medicare Part D and when necessitated by coverage changes. You may also request a copy at any time from our Customer Care Center (see front page).

USERRA RIGHTS: If you are on military leave governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents. If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

FMLA NOTICE: The VEBA Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your VEBA Plan account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave. For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

WOMENS' HEALTH AND CANCER RIGHTS ACT NOTICE: The Plan will provide coverage for all stages of reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to provide a symmetrical appearance; prostheses; and coverage of physical complications at all stages of the mastectomy, including lymphedemas. Availability of benefits may be limited by your HRA coverage and account balance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Availability of benefits may be limited by your HRA coverage and account balance.

TRICARE: Under statutory amendments enacted in 2006, and final regulations issued in 2010, employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under the military's healthcare program, known as TRICARE. In particular, employers are prohibited from providing financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a group health plan that would (in the case of such enrollment) be a primary plan. Due to these federal regulations, if you are a TRICARE-eligible employee, your employer may be required to direct your contributions to the Post-separation HRA Plan. VEBA Plan coverage is not primary to your employer's group health plan..

MEDICAL SUPPORT ORDERS: Participants and covered individuals may obtain a copy of the qualified medical support order procedure from the Plan, free of charge. To request a copy, please contact our Customer Care Center (see front page).

PRIVACY NOTICE: This Privacy Notice (the "Notice") describes the legal obligations of VEBA Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, PHI is health information, including demographic information, collected from you or created or received by the Plan from which it is possible to individually identify you and relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Questions about this Notice or our privacy practices should be directed to our Customer Care Center at (see front page).

Who Will Follow This Notice. This Plan and any service providers who assist in the administration of Plan claims are required by law and by contract with the Plan to follow this Notice. A record of your healthcare claims reimbursed under this Plan is kept for administration purposes only. This Notice applies to all medical records maintained by the Plan.

Effective Date. This Notice is effective January 1, 2015.

Privacy Pledge; Our Responsibility. We are required by law to (1) make sure PHI identifying you is kept private; (2) give you certain rights with respect to your protected health information; (3) provide this Notice of our legal duties and privacy/security practices concerning protected health information about you; and (4) follow the terms of the Notice currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make a material change to the Notice, we will provide you with a copy of our revised Privacy Notice by posting the updated Notice on the Plan website, and include information about the revised Notice and how you can obtain it in your next eligible participant account statement delivery.

How We May Use and Disclose PHI About You. The following categories describe various ways we use and disclose PHI. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories: **(1) For payment (as described in applicable regulations).** We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from healthcare providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your healthcare provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share PHI with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments. **(2) For healthcare operations (as described in applicable regulations).** We may use and disclose PHI about you for other Plan operations necessary to run the Plan. For example, we may use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. **(3) To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive,

create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. **(4) As required by law**. We will disclose PHI about you when required to do so by federal, state, or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action. **(5) To avert a serious threat to health or safety**. We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician. **(6) To Employers**. For the purpose of administering the Plan, we may disclose PHI to certain employees of your employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special Situations. In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization: **(1) Military and veterans**. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority. **(2) Workers' compensation**. We may release PHI about you for workers' compensation or similar programs providing benefits for work- related injuries or illness. **(3) Public health risks**. We may disclose PHI about you for public health activities such as to (a) prevent or control disease, injury or disability; (b) report births and deaths; (c) report child abuse or neglect; (d) report reactions to medications or problems with products; (e) notify people of recalls of products they might be using; (f) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (g) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law). **(4) Health oversight activities**. We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws. **(5) Lawsuits and disputes**. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested. **(6) Law enforcement**. We may release PHI if asked to do so by a law enforcement official (a) in response to a court order, subpoena, warrant, summons, or similar process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct at the hospital; and (f) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime. **(7) National security and intelligence activities**. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **(8) Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official necessary (a) for the institution to provide you with healthcare; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

Required Disclosures. The following is a description of disclosures of your PHI we are required to make: **(1) Government audits.** We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule. **(2) Disclosures to you**. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other Disclosures. (1) Personal representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (a) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (b) treating such person as your personal representative could endanger you; and (c) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative. **(2) Spouses and other family members**. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your rights regarding PHI about you"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications. **(3) Authorizations**. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization.

You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights Regarding PHI About You. You have the following rights regarding PHI we maintain about you: **(1) Right to inspect and copy**. You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to our Customer Care Center (see front page). We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed. **(2) Right to amend**. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to our Customer Care Center (see front page) including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement. **(3) Right to an accounting of disclosures**. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (a) disclosures for purposes of treatment, payment, or health care operations; (b) disclosures made to you; (c) disclosures made pursuant to your authorization; (d) disclosures made to friends or family in your presence or because of an emergency; (e) disclosures for national security purposes; and (f) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to our Customer Care Center (see front page). Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. **(4) Right to request restrictions**. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, healthcare operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. We will comply with any restriction request if (a) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (b) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full. To request restrictions, you must submit a written request to our Customer Care Center (see front page) detailing (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply (i.e., your spouse). **(5) Right to request confidential communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to our Customer Care Center (see front page) specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests. **(6) Right to be notified of breach**. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI. **(7) Right to a paper copy of this Notice**. You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, log in at **veba.org** or contact our Customer Care Center (see front page).

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the VEBA Plan Service Manager, at 1-800-888-8322, who will refer you to your Plan's Privacy Official. You will not be penalized or otherwise retaliated against for filing a complaint.

Other Uses of PHI. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

Part IX
Exemption from Annual Limit Restrictions

The Affordable Care Act prohibits health plans from applying dollar limits on coverage for certain benefits. Your HRA has been designed based upon exemptions from these annual limit restrictions and in accordance with guidance issued by the Internal Revenue Service and the U.S. Department of Health and Human Services. Accordingly, your HRA reimbursements (claims) are limited to your available account balance. This means coverage provided to you by this Plan may not reimburse all of the out-of-pocket medical care expenses you may incur.

Additionally, if you are a resident of Washington or Oregon, you can contact your local Consumer Assistance Program using the information below.

Washington Consumer Assistance Program
5000 Capitol Blvd, Tumwater, WA 98501
1-800-562-6900
cap@oic.wa.gov

Part X
Terms & Conditions

By enrolling and participating in the VEBA Plan and taking any action with respect to your HRA benefits under the Plan, you agree to the following Terms & Conditions. You agree that the Plan and the parties involved in this Plan (including, but not limited to, the employer, your bargaining representative, the Trustee(s), the VEBA Plan, Service Manager, Plan service providers, and the agents of each, collectively referred to as the "Plan and its agents") cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any tax, charge, penalty, assessment, or other amount that is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan and its agents harmless with respect to such withholding or any failure to withhold or pay such amounts and any other actions taken in good faith for the operation of the Plan.

You understand that for proper administration of the Plan and compliance with applicable law, you must provide true and accurate information to the Plan and regularly confirm and update your enrollment information, including name, address, phone number, dependents, and social security numbers for yourself and your dependents. Information submitted to the Plan fraudulently may result in adverse tax consequences or penalties and/or your termination from the Plan. You also understand that it is your responsibility to review each statement to confirm that there are no investment or financial errors reflected on your account. Any errors must be reported by you to the Plan within ninety (90) days after the error is first viewed by you online or first reflected in a statement or other written information delivered to you by the Plan and its agents.

E-communication Terms & Conditions. For your e-communication election to be effective, you must provide the Plan with your e-mail address. The electronic documents you will receive include e-statement notifications and newsletters, claims processing notifications, and other important Plan information. Please note the following: (1) you may withdraw your consent for electronic documents at any time at no charge; (2) to update your e-communication election or email address, please login to **veba.org** and click on **My Profile** on the menu bar; (3) it is your responsibility to keep your email address current with the Plan. If your electronic documents are returned to the Plan due to an undeliverable e-mail address, the Plan may remove your e-communication election; (4) any electronically delivered documents will **not** be mailed to you by US Mail; and (5) you can view and print copies of your electronic documents or request paper copies (at no charge) from our Customer Care Center (see front page).

You will need Adobe Acrobat Reader software loaded on a computer in order to access electronic documents. A free copy of Adobe Acrobat Reader is available at www.adobe.com.

Ask Questions
1-888-828-4953

More Information
veba.org