SUMMARY PLAN DESCRIPTION

and

Restated

MEDICAL EXPENSE REIMBURSEMENT PLAN

of the

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST

Based on Plan effective November 16, 2015

Including COBRA General Notice and
HIPAA Notice of Privacy Practices

11/05/15 Dr. and incl. Ams. 1-23 (Plan)
11/05/15 (Booklet)

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST
NOVEMBER 2015

Dear Participants in the Washington State Council of Fire Fighters Employee Benefit Trust:

The Washington State Council of Fire Fighters has established the Medical Expense Reimbursement Plan ("MERP" or the "Plan") of the WSCFF Employee Benefit Trust (the "Trust") to provide an important piece of financial support during your retirement. Your participation in MERP means you are building a fund to assist with medical costs you will incur after you retire. Your Local has negotiated contributions to the Trust in your Collective Bargaining Agreement.

The Trust is highly tax-favored. The contributions are pre-tax dollars; Trust earnings are not taxable; and when you begin receiving benefits in the future, they will not be taxed (unlike pension payments, which are taxed).

The WSCFF Employee Benefit Trust is controlled by a Board of Trustees, who are fellow fire fighters selected by the membership of participating Locals or the WSCFF Executive Board. We are very pleased to provide you this booklet, which contains a "Summary Plan Description" that provides general information about the operation of MERP in a Question-and-Answer format, and describes the rights and protections to which you are entitled under federal law. In addition, this booklet contains the Plan itself, as well as the HIPAA Notice and General COBRA Notice.

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

Please contact one of the Trustees if you have any questions or comments on the Plan.

Fraternally,
Kelly L. Fox, Chairman
WSCFF Employee Benefit Trust Board of Trustees, and
WSCFF President

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

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SECTION I

SUMMARY PLAN DESCRIPTION

11/05/15 dr.

HIGHLIGHTS OF THE PLAN

- Eligibility. Generally, Employees need five (5) years in MERP to achieve eligibility for monthly benefits from the Trust. However, for Employees who are within five years of retirement when their Local joins the Trust, there will be a limited benefit – See Q & A #3 below.

- Benefits. Your benefits from this Trust come in the form of monthly reimbursement for certain medical costs, which are called "Covered Expenses,"[1] incurred after you retire, limited to the amount of your monthly benefit level. Contact the Trust Office to find out your benefit level.

- Claims. You must present your claims to the Trust Office with your proof of payment of Covered Expenses, on a form approved by the Trustees, no later than March 31 of the following year from the date on which you made the payment of the Covered Expense. However, you are encouraged to submit your claims throughout the plan year.

- Change of Address or Family Composition. If you move or have a change in mailing address, it is your responsibility to update the mailing address on file with the Trust Office. It is also your responsibility to update the information on file with the Trust Office if you have a change in family composition, e.g., marriage, divorce, or birth of a child. Failure to notify the Trust Office may result in loss or delay of benefit payments.

- Trust Office (Administrator). The Trust Office is a valuable resource and provides important services to the Trust. For example, to find out your benefit level, submit any benefit claims, request a copy of the Plan or notify the Trust of a change in address, you may need to contact the Trust Office. The Trust Office may be contacted at the following:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 771-7359
Fax: (866) 601-4397
wscffmerp@bsitpa.com

NOTE: The Questions & Answers in this Summary Plan Description have been designed to provide you with key information about the WSCFF Employee Benefit Trust but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust," restated effective November 16, 2015, as amended from time to time thereafter, which is contained in this booklet. If there is a conflict between what is contained in the Plan, and what is contained in the Summary Plan Description or any other descriptions, the terms of the Plan will prevail.

[1] Capitalized terms contained herein are defined in the formal Plan document, and many are described in this Summary Plan Description. You can find the formal Plan document following the SPD in this booklet.

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTION

TABLE OF QUESTIONS

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Summary Plan Description

1. Who can participate in MERP (or the "Plan")?

Eligibility in MERP (or the "Plan") is generally open to all Employees who are members of a bargaining unit represented by a member Local of WSCFF (or a Local of the International Association of Fire Fighters), and for whom contributions are made to the Trust as required by the Collective Bargaining Agreement between that Local and the Employee's Employer.

NOTE re promotions: If you promote out of a participating bargaining unit, you may be able to continue participation under limited circumstances, e.g., a CBA between a management bargaining unit and the Employer. Contact the Trust Office for details.

2. Who is eligible for benefits?

An Employee described in Answer #1 becomes an Eligible Retiree entitled to monthly benefits under MERP, generally, after the following requirements are met**:**

- The Employee earns five years of Active Service in the Trust (see Q&A No.3).
- Contributions are made to the Trust on behalf of the Employee for all years of Active Service.
- The Employee attains age 53.
- The Employee ceases employment with a Participating Employer.

An Eligible Retiree is generally entitled to a lifetime stream of monthly benefit payments at his/her benefit level, for reimbursement of medical expenses.[2] See Plan Sections 3.2 – 3.3 in this booklet for details.

3. How do I earn Active Service?

An Employee may earn Active Service in the following ways.

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

Conversion of Leave. The Trust Office will convert the full amount of any mandatory transfers of sick and/or vacation leave to the Trust into years (or partial years) of Active Service, first by converting the leave transfer into Active Service Units, according to an

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

actuarial formula set by the Trustees in consultation with the Plan's actuary. Then, for each thirty-six (36) ASUs, the Employee will earn one additional year of Active Service.

Contribution after Termination of Reduction of Employment. If your employment is terminated (except for gross misconduct) or reduced to less than full-time, you may continue to earn Active Service for a maximum of eighteen months, by making periodic self-payments to the Trust as permitted by the federal law known as COBRA,[3] and subject to rules set by the Trustees.

(If conversion of leave or continued self-payment enables an Employee to reach the minimum requirement of five years of Active Service, the Trust Office will add the Active Service Units relating to the additional years or partial years of Active Service to the number of Active Service Units otherwise earned by the Employee in calculating the Employee's monthly benefit level. See Q&A No. 7. However, if the conversion of leave or continued self-payment does not enable an Employee to reach the minimum requirement of five years of Active Service, the value of the leave transfer or self-payments will be added to the total amount of contributions made on his/her behalf. See Q&A No. 4.)

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

An Employee who does not earn five years of Active Service will not be eligible to receive the lifetime[4] stream of monthly benefit payments. Instead, he/she will be eligible to receive benefits limited to the total amount of contributions made on his/her behalf, including the value of any leave transfers or self-payment contributions (without any allocation for investment returns thereon). This type of Employee may submit claims for the reimbursement of Covered Expenses at any time after separation from employment as an Employee in the Trust. There is no monthly limit on the amount, as long as all claims are for reimbursement of Covered Expenses. Benefits cease when the Employee has been reimbursed for Covered Expenses in an amount equal to the total amount available to him or her as described above.

See Plan Sections 2.1, 2.2(a)(4), 2.2(b), and 3.2(h) in this booklet for details.

5. What are the benefits from the Trust?

After meeting the eligibility requirements, Eligible Retirees are entitled to reimbursement toward the payment of Covered Expenses, which generally consist of insurance premiums and medical expenses paid and incurred by the Employee after the Employee retires and becomes eligible for benefits under MERP. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment for a Beneficiary who qualifies for the lifetime[5] stream of benefit payments is limited to the Beneficiary's monthly benefit level. See Q&A No. 7.

[3] The Consolidated Omnibus Budget Reconciliation Act of 1986.
[4] MERP is currently written to provide benefits for most Retirees until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of MERP.
[5] See footnote 3.

However, for an Employee who does not earn the five years of Active Service, his/her benefits are limited to the total amount of contributions made on his/her behalf. See Q&A No. 4.

Cost Sharing. Also, it is important to remember that MERP reimburses toward the cost of Covered Expenses, but your benefit level may not cover the entire amount of the Covered Expense. If your benefit level does not cover the entire cost of your Covered Expense, you will be responsible for the balance of any Covered Expense.

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

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

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

- Premium or contribution payments for coverage under health, dental, or vision insurance plans, for types of medical expenses excludible from gross income under Internal Revenue Code ("Code") Section 105(b).

- Medical expenses as defined in Code Section 213(d), i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs. For a complete list, see IRS Publication 502, which you can find at www.irs.gov/pub/irs-pdf/p502.pdf.

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

See Plan Section 1.8 in this booklet for a full definition of Covered Expenses.

Please note that a payment to a health care sharing ministry, such as Samaritan ministries, Christian Care Ministry's Medi-Share program, or Christian Healthcare Ministries, does NOT qualify as a Covered Expense. This is because a payment, contribution or gift, to a health care sharing ministry does not fit within the IRS rules for a permissible expense. The Trust must comply with these rules in order to preserve the tax benefits of MERP for all participants.

If you have a question about whether an expense will qualify for reimbursement, you may contact the Trust Office at (425) 771-7359.

7. How is my monthly benefit level calculated? What is the difference between "Active Service" and "Active Service Units" ("ASUs")?

An Eligible Retiree's monthly benefit level is determined by the number of Active Service Units he/she has accrued, and the Unit Multiplier in effect when he/she stops making contributions.

- An Employee earns Active Service Units for each contribution to the Plan. Each monthly contribution of $25 is equal to one Active Service Unit. For example, if your Local's monthly contribution rate is $75, you will earn three Active Service Units a month.

- The Unit Multiplier is a factor determined by the Trustees, with actuarial advice, which allows the Plan to pay benefits for the lifetime of all Eligible Retirees who qualify for the lifetime stream of benefits.[6]

After retirement, the Trust Office will calculate your monthly benefit level by the following methodology (as further described in Plan Section 3.2, and illustrated in Appendix A of the Plan, later in this booklet):

- Determine your total number of Active Service Units and

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

From time to time, the Trustees will determine the Unit Multiplier, as defined in Plan Section 1.21, with the assistance of professional actuarial advice. You may contact the Trust Office to find out the current Unit Multiplier, which may change from time to time.

Conversion of Leave into ASUs. An Employee may also earn Active Service Units through conversion of leave transfers into Active Service Units at actuarial cost, which is based on the actual age of the Employee at the date of transfer. To find out the actuarial cost of your leave conversion, please refer to Appendix C to the Plan, "Leave Conversion Table," effective July 1, 2015, located later in this booklet.

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

Continued Self-Payment. If an Employee is terminated (except for gross misconduct) or reduced to less than full-time, he/she may continue to earn Active Service Units for a maximum of eighteen months, by making periodic self-payments to the Trust, under COBRA and subject to rules set by the Trustees.

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

- Active Service reflects periods of employment when your employer transfers contributions to the Trust on your behalf. Your length of Active Service is one of the factors that determine your eligibility for monthly benefits as an Eligible Retiree.

- "Active Service Units" reflect the number of $25 contributions made on your behalf to the Trust. The number of Active Service Units is a factor in determining your benefit level.

[6] See footnote 3.

8. Why are there differences in the monthly benefit level between participants?

An Eligible Retiree's monthly benefit level is calculated by the methodology described in Q&A No. 7 above. Each Eligible Retiree's monthly benefit level will be affected by the number of Active Service Units earned by that Employee over his or her career. An Employee earns one Active Service Unit for each monthly contribution of $25 to the Trust on his or her behalf. The monthly contribution rate is negotiated by the Employee's bargaining unit. For example, a monthly contribution rate of $75 will provide to each employee in that bargaining unit three Active Service Units per month, whereas a monthly contribution rate of $100 will earn four Active Service Units per month. Thus, Eligible Retirees from different Locals will have different monthly benefit levels, depending upon what contribution rate their Local selected and negotiated. And even within the same Local, benefit levels may vary based on the period of Active Service in the Plan.

9. Will my benefit level remain constant for my lifetime?

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

However, there is one adjustment to benefit levels that you may choose. Eligible Retirees who became (or become) eligible *on or after* August 20, 2014 may select from four different benefit level options at the time they first apply for benefits. Option 1 provides a constant benefit level for your lifetime. Each of the next three options allows you to select a higher benefit level immediately after you first apply for MERP benefits until age sixty-five (65) and a reduced benefit level after age sixty-five (65). Specifically, the four options allow an Eligible Retiree to select:

- OPTION 1: a constant benefit level for life;
- OPTION 2: an initial benefit level until age sixty-five (65) that is 1.5 times higher than the benefit level that the Eligible Retire will receive after he/she attains age sixty-five (65); that is, the benefit level will be reduced at age 65;
- OPTION 3: an initial benefit level until age sixty-five (65) that is 2 times higher than the benefit level that the Eligible Retiree will receive after he/she attains age sixty-five (65); or
- OPTION 4: an initial benefit level until age sixty-five (65) that is 3 times higher than the benefit level the Eligible Retiree will receive after he/she attains age sixty-five (65).

You will be asked to select from among these options when you commence your benefits. Once made, your selection will not be permitted to change your selection and will apply

to any survivor's benefit as well.

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

- Default Option: If you do not make a choice within the time frame that the Trust Office gives you, then you will automatically be defaulted into Option 1, which is the constant benefit level for life.

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

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

If you die before you make a selection, your beneficiary will receive 50% of your benefit level as calculated under Option 1, i.e., the Default Option.

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

10. What happens if I delay the commencement of my benefit?

An Eligible Retiree who has earned five years of Active Service at the time he/she attains age fifty-three (53) may decide to defer the commencement of all benefits from the Plan. An Eligible Retiree who chooses to defer benefits will earn additional Active Service Units for each year of deferral beyond age fifty-three (53). For each year of deferral, the Trust will grant Active Service Units to the Retiree in an amount equal to the average number of Active Service Units the Retiree earned per year during active employment.

11. What happens if I have an expense that exceeds my monthly benefit level?

If a Beneficiary submits a claim for a Covered Expense that is greater than his/her monthly benefit level, then the excess will be carried over and paid in subsequent months, up to his/her monthly benefit level. However, any unused balance of his/her monthly benefit level will not be carried over to the next month. For example, consider an Eligible Retiree with a monthly benefit level of $200. In February, he submits a claim for a Covered Expense of $150 incurred in January. The Plan will reimburse him for $150; there is no $50 carryover to February. Note that if a Beneficiary submits a Covered Expense later than the

month in which it was incurred, it will be treated as if it was submitted in the month that it was incurred

12. What will the benefit level be for my spouse and children in the event of my death?

The monthly benefit level for a Surviving Spouse is equal to 50% of the benefit level of the deceased Eligible Retiree. If there is no Surviving Spouse or Surviving Domestic Partner, the monthly benefit level for Surviving Children will be 50% of the benefit level for the deceased Eligible Retiree (to be divided equally among Children). A Surviving Spouse or Child is entitled to benefits beginning the month after the death of the Eligible Retiree. Children include the natural and adopted children, stepchildren and foster children of the Eligible Retiree who are under the age of 26. Children who are over the age of 26 who are legally dependent upon the Eligible Retiree and determined to be totally disabled by the Social Security Administration are also eligible Beneficiaries.

Note that the Surviving Spouse, Surviving Domestic Partner (see Q&A 13 below), or Surviving Child of an Eligible Retiree who did not qualify for the lifetime stream of monthly benefits will not be entitled to a monthly benefit. Instead, such Surviving Spouse, Surviving Domestic Partner, or Surviving Child will be entitled to reimbursement of Covered Expenses limited generally to the amount of contributions made on behalf of the deceased Eligible Retiree (and subject to the limitations described below for Surviving Domestic Partners). See Plan Section 3.2(h) in this booklet.

13. Are there benefits for my Domestic Partner in the event of my death?

The monthly benefit level for a Surviving Domestic Partner will be the same as for a Surviving Spouse, subject to certain limits under federal tax law. The Domestic Partner of an Employee or Eligible Retiree must meet the definition of Domestic Partner under the applicable local municipal statute in order to be eligible for benefits; in the absence of such a statute, the definition in the Revised Code of Washington will apply.

Federal tax law provides that the aggregate amount paid to all Domestic Partners under the Plan annually shall not exceed 3% of the total benefits paid annually, which shall be calculated within thirty calendar days after the end of each Plan year. See Plan Section 3.2(d)-(f) in this booklet.

The IRS has issued guidance indicating that, to the extent coverage is provided to *nondependent* Domestic Partners, the value of such coverage under the Plan for nondependent Domestic Partners will be included in the employee's gross income for a taxable year if he or she is expected to have a nondependent Domestic Partner upon becoming eligible for benefits under the Plan. The amounts to be included in the employee's gross income will be determined under a valuation that takes into account reasonable actuarial assumptions. Please advise the Trust Office if you have a Domestic Partner so that the Trust and Beneficiaries will not lose the tax benefits afforded by MERP.

14. How do I submit my claims for benefits? What are the appeal procedures for denied claims?

To present a claim for benefits under this Plan, a Beneficiary must submit a claim on a form approved by the Trustees to the Trust Office no later than March 31st of the year following the date on which the Beneficiary paid the Covered Expense. For example, all Covered Expenses which the Beneficiary paid in the year 2015 must be submitted for reimbursement no later than March 31, 2016. (However, the Trust Office may waive the deadline for good cause shown, according to guidelines set by the Trustees.) The Trust encourages you to submit claims and receive reimbursements throughout the plan year. Beneficiaries may contact the Trust Office to request an approved claim form.

You must submit your claim to the Trust Office at:

WSCFF Employee Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Fax: (866) 601-4397
Email: wscffmerp@bsitpa.com.

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

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Details for claim submission and appeal of claim denial are set forth in Article III, Section 3.5, and Article IV of the Plan in this booklet. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

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

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

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

16. What is the Plan Year?

The Plan year runs from July 1 through June 30.

17. What should I do if I change my address, spouse, domestic partner or dependents?

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

- Changes in your mailing address;
- Changes in your employment status (e.g., retirement, lay-off, or reduction in hours);
- Changes in your spouse or domestic partner (e.g., divorce, marriage, or death); and
- New children (e.g., by birth or adoption).

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

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

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include failure by the Employee or employer to make required contributions, failure to properly submit expense receipts, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note the following events will cause termination of benefits:

- An Eligible Retiree's benefits under this Plan will terminate upon his/her death, or if he/she returns to employment with a Participating Employer.

- A Surviving Spouse's benefits under this Plan will terminate on the date the Spouse becomes eligible for Medicare, even if he or she does not adequately enroll for Medicare, or death, whichever occurs first.

- A Surviving Domestic Partner's benefits under this Plan will terminate on the date the Domestic Partner becomes eligible for Medicare, even if he or she does not adequately enroll for Medicare, or death, whichever occurs first.

- A Surviving Child's benefits under this Plan will terminate upon the loss of Child status or death, whichever occurs first.

Benefit coverage and benefit levels may be modified or terminated pursuant to Article VI of the Plan and such changes may apply to current and/or future Beneficiaries.

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

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

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

Kelly L Fox, Chair
Greg Markley, Treasurer
Matt Frank
Brian Hurley
Brian Murphy
Craig Soucy
Ken Stuart
Jeff Wainwright
Ricky Walsh

c/o Washington State Council of Fire Fighters
1069 Adams Street Southeast
Olympia, WA 98501

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

A. The name of the Plan and Trust.

This Plan is known as the "Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust," effective July 28, 2015, and as amended from time to time thereafter (the "Plan," *11/02/15 Dr.*). The Plan is governed by the "Trust Agreement Governing the Washington State Council of Fire Fighters Employee Benefit Trust," restated effective April 14, 2004 and as amended thereafter ("Trust Agreement"). For a copy of the Plan or Trust Agreement, please contact the Trust Office. Also, the Plan is printed later in this booklet.

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

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

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

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

C. The identification numbers of the Trust and Plan.

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

D. The type of plan.

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

E. The type of administration/trust office.

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

WSCFF Employee Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 771-7359
Fax: (866) 601-4397
Email: wscffmerp@bsitpa.com.

F. The identity of the Plan Administrator.

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

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

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

bargaining agreements. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

H. Information regarding the Family Medical Leave Act.

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

- the birth and care of a newborn child of the Employee;
- the placement with the Employee of a child for adoption or foster care and to care for the newly placed child;
- to care for an immediate family member (spouse, child, or parent) who has a serious health condition;
- a serious health condition that makes the Employee unable to work;
- any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter or parent is a covered military member on "covered active duty" (as defined in the FMLA); or
- to care for a covered servicemember with a serious injury or illness if the Employee is the servicemember's spouse, son, daughter, parent or next of kin.

Please contact the Trust Office if you go out on FMLA leave and would like to take advantage of your right to self-pay contributions under FMLA.

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

Please contact the Trust Office if you are a veteran leaving to, or returning from, active duty and would like to take advantage of your right to self-pay contributions under USERRA. You will be able to pay retroactively for the time of your active service duty, subject to certain restrictions.

J. Information regarding COBRA.

The General COBRA Notice is included later in this booklet. However, if you would like to request a separate copy of the General COBRA Notice, please contact the Trust Office.

K. The source of contributions to the Trust.

Contributions to this Plan must be non-elective, that is, required by a collective bargaining agrement. They may be employer and/or employee contributions. Further, under certain limited circumstances required by federal law, Beneficiaries may elect to make self-payment contributions.

L. The method that is used for the accumulation of assets.
Contributions are received and held in trust by the Trust and are invested with the assistance of a professional investment manager, using investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 (ERISA) requirements.

M. The procedures governing Qualified Medical Child Support Order Determinations (QMCSO).
Beneficiaries can obtain, without charge, a copy of such procedures from the Trust Office.

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

O. Statement of Legal Rights.

- Rights of Plan Participants. Beneficiaries of the WSCFF Employee Benefit Trust are entitled to certain rights and protection under the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

    - Obtain upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

    - If there is a cessation of contributions to the Plan as a result of a COBRA qualifying event, you or your Spouse or your Children may be allowed to continue such contributions by self-payment. Review the General COBRA Notice and the Plan, Sections 2.2(c) and 2.2(d), for rules governing your COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust

beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of this employee welfare benefit plan.

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

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

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

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

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

SECTION II

MEDICAL EXPENSE REIMBURSEMENT PLAN

Effective November 16, 2015

11/05/15 Dr., Incl. Amendments 1-23

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST

MEDICAL EXPENSE REIMBURSEMENT PLAN

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WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

MEDICAL EXPENSE REIMBURSEMENT PLAN

PREAMBLE

WHEREAS, the Washington State Council of Fire Fighters established a benefit trust for the purpose of funding health insurance benefits for fire fighter Locals throughout the State of Washington and other states, granting administration of the Trust to a Board of Trustees pursuant to the "Trust Agreement Governing the Washington State Council of Fire Fighters Employee Benefit Trust," (restated eff. April 14, 2004); and

WHEREAS, the Board of Trustees adopted the Premium Reimbursement Plan of the Washington State Council of Fire Fighters Employee Benefit Trust, originally effective July 1, 1999 (the "Plan"), which was restated effective October 1, 2003 (to include Plan Amendments 1-7, including Amendment No. 5 effective January 1, 2003, which changed the name of the Plan to the Medical Expense Reimbursement Plan); and restated again effective November 1, 2005 (to include Plan Amendments 1-10; and restated again effective October 1, 2007 (to include Plan Amendments 1-14); and restated again effective December 1, 2009 (to include Plan Amendments 1-15); and thereafter amended eight times (Plan Amendments 16-23); and

NOW, THEREFORE, the Board of Trustees does hereby adopt this restated Medical Expense Reimbursement Plan of the Washington State Council of Fire Fighters Employee Benefit Trust, including Amendment Nos. 1 through 23, and further modifications for clarity and scrivener's errors, effective July 28, 2015, unless otherwise specifically stated, as set forth in the following pages.

ARTICLE I
DEFINITIONS

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

1.1 (a) **"Active Service"** means service as defined in Section 2.2 herein, on or after an Employee's Effective Date. Active Service is a factor used to determine eligibility to become an Eligible Retiree under Section 2.1.

(b) An **"Active Service Unit**" or **"ASU"** is generally earned through a monthly Contribution of $25 to the Trust on behalf of an Employee. Note that an Employee may earn more than one Active Service Unit in a month. The number of ASUs an Employee earns is a factor in determining his/her benefit level as an Eligible Retiree under Section 3.2(a) hereof.

1.2 **"Beneficiary"** means an Eligible Retiree, his or her lawful spouse or Domestic Partner and the Eligible Retiree's Children; and an Eligible Retiree's Surviving Spouse or Domestic Partner, and the Eligible Retiree's Surviving Children.

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

1.4 "**Child(ren)"** means a natural child[, stepchild,] or lawfully adopted child of the Eligible Retiree, or child placed in the Eligible Retiree's home for adoption by the Eligible Retiree, who either:

(1) is under the age of 26; or

(2) is legally dependent upon the Eligible Retiree for support and maintenance, for so long as the child is determined to be totally disabled by the Social Security Administration..

"Surviving Child(ren)" means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Eligible Retiree's death and who continues to meet those requirements.

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

1.6 "**Collective Bargaining Agreement**" means a written agreement between a participating employer and a Local, and any supplement, amendment, continuation, or renewal thereof, by the terms of which the employer or its employees are obligated to make mandatory contributions to a trust for the types of benefit plans administered by the Trustees on behalf of each and every employee in the bargaining unit, at the rate then currently required by the Trustees. The term also includes a written agreement by the employer that covers all Employees who have promoted from the bargaining unit, which otherwise meets the definition of a Collective Bargaining Agreement.

1.7 **"Contribution"** means a mandatory contribution for each and every employee in a bargaining unit or other rational class made pursuant to a Collective Bargaining Agreement or other written agreement of a participating employer, as defined herein. Except for transfer of accumulated leave, the contribution shall be made at the monthly rate of $75 per employee, or $25 increments above $75, provided that when a Local first joins the Trust, it may commence participation at a monthly rate of $50 per employee**.** A contribution must be made without any election on the part of an individual employee (except for contributions made pursuant to continuation requirements of federal law under IRC Section 4980B (COBRA)).

1.8 **"Covered Expense"** means payment for the following, incurred by a person who has become eligible to commence benefits under Section 3.3 hereof, on behalf of himself or his or her Spouse, Domestic Partner, and Children:

(a) a premium or contribution payment on behalf of a Beneficiary to a health, dental or vision insurance plan, for coverage of the Beneficiary in effect while the Beneficiary

is eligible for benefits under this Plan, for the type of medical expenses excludible from gross income under Code Section 105(b);

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

(c) a premium payment for long-term care insurance, qualified under Code Sec. 7702B, for coverage of the Beneficiary in effect while the Beneficiary is eligible for benefits under the Plan, but for no other expenses associated with the costs of long-term care.

1.9 **"Domestic Partner"** means an individual named by an Employee or Eligible Retiree as his or her domestic partner in an affidavit filed with the Trust Office, who with the Employee or Eligible Retiree meets the requirements to establish a domestic partnership pursuant to either the applicable local municipal statute or the Revised Code of Washington Chapter 26.60, *et seq.* In lieu of filing an affidavit with the Trust Office, an Employee or Eligible Retiree may present to the Trust Office a Certificate of State Registered Domestic Partnership or a Wallet Card of State Registered Domestic Partnership issued by the state of Washington. The domestic partnership as described here must have been in effect for at least 12 months on the date of the Retiree's death.

1.10 **"Effective Date"** for an Employee means the date that the Employee or his or her employer was obligated to begin contributions to the Plan for that Employee, pursuant to a Collective Bargaining Agreement.

1.11 **"Eligible Retiree"** means an Employee who is entitled to benefits under Section 2.1 of the Plan. An **"Eligible Retiree with Short Service**" is a person who has become eligible for benefits under Section 3.2(h).

1.12 **"Employee"** means an individual employed by a participating employer on or after that Employee's Effective Date, who is a member of a bargaining unit represented by a Local, or who has promoted out of such bargaining unit, and for whom the required contributions are made to the Trust for all periods of Active Service.

1.13 **"Local"** means a labor organization that (1) is a member local of the WSCFF, or is a member local of the International Association of Fire Fighters (IAFF); and (2) represents fire fighter and paramedic employees; and (3) is party to a Collective Bargaining Agreement with a participating employer; and (4) has been accepted for participation by the Board of Trustees.

1.14 **"Operative Date"** means the date on which the corresponding Unit Multiplier is effective. See Appendix B to the Plan.

1.15 **"Participating employer"** means any public or private sector employer that is party to a Collective Bargaining Agreement with a Local, which provides for contributions to this Plan.

1.16 **"Plan"** means this separate written document, together with any amendments duly adopted by the Trustees.

1.17 **"Surviving Domestic Partner"** means the Domestic Partner of an Employee who was the Domestic Partner of the Employee for at least 12 months on the date of the Employee's death.

1.18 **"Surviving Spouse"** means the lawful spouse of an Eligible Retiree to whom the Retiree was married for at least 12 months on the date of the Retiree's death.

1.19 **"Trust"** or **"Trust Fund"** means the Washington State Council of Fire Fighters Employee Benefit Trust created by the Trust Agreement, and all property and money held by such entity, including all contract rights and records. "**Trust Office"** means the contract administrator hired by the Board of Trustees to administer day-to-day operations of the Trust.

1.20 **"Trust Agreement"** or **"Agreement"** means the Trust Agreement governing the Washington State Council of Fire Fighters Employee Benefit Trust, effective July 1, 1999, and any amendments thereto.

1.21 **"Unit Multiplier" or "UM"** means the variable amount periodically set by the Trustees, based on demographic and financial factors, and used in the determination of the monthly benefit level of an Eligible Retiree, as set forth in Section 3.2(a). The Trustees may adjust the UM from time to time.

1.22 **"WSCFF"** means the Washington State Council of Fire Fighters.

ARTICLE II
ENTITLEMENT TO BENEFITS

2.1 **Eligibility**. An Employee shall become an Eligible Retiree when he or she meets all the following conditions:

(a) Subject to subsection 2.1(e) hereof, the Employee has earned five years of Active Service;

(b) Contributions have been made to the Plan on behalf of the Employee for all periods of Active Service ; and (except if the Active Service is earned under Section 2.2 (a)(2) or (3) or Section 2.2(c) hereof).

(c) The Employee attains age 53; and

(d) The Employee ceases employment with his or her participating employer.

(e) Separation from employment prior to five years of Active Service. Effective for an Employee who separates from employment as an Employee on or after

October 1, 2007, prior to earning five years of Active Service, the Employee may become an Eligible Retiree and entitled to benefits only as described under Section 3.2(h) below. An Employee who separates from employment prior to earning five years of Active Service cannot elect to self-pay contributions to the Trust Fund in order to obtain benefits under Section 3.1 hereof, with the exception of Employee self-pay contributions under Section 2.2 (c).

2.2 Active Service and Active Service Units.

(a) Bargaining Unit Employment. Active Service is used to determine an Employee's eligibility under this Plan. An Employee shall earn Active Service as follows:

(1) For full-time employment as an Employee;

(2) For time as an Employee on authorized paid leave of absence, or unpaid leave under the federal Family and Medical Leave Act, from a participating employer due to disability, illness, or injury; and

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

(4) For conversion of leave transfers to Active Service Units, pursuant to the rules in Section 2.2(b) below, for the purpose of meeting the Active Service threshold required for eligibility under Section 2.1(a); provided that, for such purpose, thirty-six (36) Active Service Units are required to earn one (1) year of Active Service.

If the Active Service earned by an Employee through the conversion of leave accumulation is not sufficient to enable the Employee to reach the Active Service threshold set forth in Section 2.1 (a), the value of the leave accumulation will be added to the amount available to the Employee as an Eligible Retiree with Short Service, as set forth under Section 3.2 (h) of the Plan.

(b) Conversion of Leave to Active Service Units. An Employee may earn Active Service Units by transfer of leave accumulation, which includes only sick and/or vacation leave, into the Plan, annually or upon retirement, pursuant to a non-elective requirement for such transfer in his or her Collective Bargaining Agreement. Effective for amounts transferred and received by the Trust Office on or after January 1, 2007, the Plan shall convert the full amount of the leave accumulation into Active Service Units according to a formula set by the Trustees, in consultation with the Trust's actuary, and reflected in the Leave Conversion Table in Appendix C hereto, which may be revised by the Trustees from time to time. The Leave Conversion Table in effect on the date of transfer of leave shall apply. Appendix C is hereby incorporated and made a part of this Plan (current version marked Eff. 7/1/15 is attached hereto and all future versions will be attached to this Plan with effective dates indicated).

(c) Contribution after Termination or Reduction of Employment (COBRA). An Employee whose employment is terminated (except for gross misconduct) or reduced to less than full-time, may continue to earn Active Service and/or Active Service Units for a maximum of eighteen months, by periodic self-payment pursuant to rules set forth by the Trustees.

(d) Surviving Spouse or Child Contribution after Death of Employee (COBRA). After the death of an Employee, a Surviving Spouse or Surviving Child may continue to earn Active Service and Active Service Units by periodic self-payment of Contributions, for a maximum of thirty-six months, pursuant to rules set by the Trustees. Self-payment rules may be obtained from the Trust Office.

2.3 Required Self-Payments. An Employee, Eligible Retiree, Surviving Spouse, or Surviving Child who is eligible or required to make self-payments to this Plan shall be responsible to make or arrange for such payments to the Trust according to rules set by the Trustees. Please inquire at the Trust Office for details.

2.4 No Rebate or Refund. Beneficiaries and/or Employees shall not be eligible for rebates or refunds of any contributions made, except as reimbursement of Covered Expenses; provided, however, that any elective contributions (other than COBRA contributions under IRC Section 4980B) will be returned within thirty days of discovery that the contribution was made by individual election, and Active Service granted based on an elective contribution will be rescinded.

ARTICLE III
BENEFITS

3.1 Payment of Benefits.

(a) General. Subject to the exclusions and limitations set forth in this Plan, a Beneficiary is entitled to monthly reimbursement of Covered Expenses paid by the Beneficiary on behalf of a Beneficiary, and incurred after the Employee becomes an Eligible Retiree, subject to proper and timely submission of claims, as set forth in Section 3.5 hereof. Monthly reimbursement shall not exceed the benefit levels set forth in Section 3.2 hereof.

(b) Monthly Payment. Subject to Section 3.1(c) hereof, benefits shall be paid monthly, up to the Beneficiary's benefit level as set forth in Section 3.2.

(c) Carryover of Excess Expenses. Amounts of Covered Expenses in excess of the monthly benefit level of the Beneficiary that are properly submitted to the Trust Office shall be paid in subsequent months, up to the Beneficiary's monthly benefit level.

(d) No Carryover of Unused Monthly Payment. Subject to Section 3.1(e) hereof, any unused balance of the monthly benefit level in a month will not be carried over to

the next month.

(e) Accrual at Date of Service. A Covered Expense that is submitted later than the month in which it was incurred shall be paid as if submitted in the month it was incurred.

Example: The provisions of Section 3.1 may be illustrated as follows.

Consider an Eligible Retiree with a benefit level of $200. In January, he submits an expense voucher for a Covered Expense of $150 incurred in January. The Plan will reimburse him for $150, and there is no $50 carryover to February. He does not submit any further expense until May, when he submits an expense voucher for a Covered Expense of $550, incurred in March. The Plan will not pay any reimbursement for February, but will pay $550 in one check for the May claim ($200 for March, $200 for April and $150 for May.) There is no $50 carryover to June.

However, in the preceding example, if the Retiree had also submitted vouchers for $125 in March, April and May, then the Plan would pay him $200 for March ($125 plus $75 towards the $550 expense), $200 for April ($125 plus another $75 towards the $550 expense), and $200 for May ($125 plus another $75 towards the $550 expense). These amounts will usually be paid in one check. The $225 left of the $550 expense submitted in May, will be paid in June ($200) and July ($25), with no $175 carryover to August. If the Retiree incurred no further expenses until a $400 expense in November, the Plan would reimburse for that in November and December. There would be no reimbursement for August, September and October, unless the Retiree subsequently submits expense vouchers for expenses incurred during that August-October period. (Example assumes that Plan claim procedures were followed.)

(f) Coverage for deceased Retiree through Survivor's Benefit. A surviving beneficiary may use his or her survivor benefit, for which he or she becomes eligible following the death of the Eligible Retiree, for reimbursement of claims for Covered Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death.

3.2 Benefit Levels. The Trustees shall set the benefit levels from time to time.

(a) Eligible Retiree. An Eligible Retiree who commences benefits on and after August 20, 2014, will have a one-time, irrevocable selection among the following four benefit level options, calculated so as to be actuarially equivalent to each other.

(1) Option 1: This option allows an Eligible Retiree to receive a level benefit from commencement of benefits until termination of benefits, which is determined according to the following methodology:

A. Determine the number of Active Service Units

B. Multiply the number of Active Service Units by the Unit Multiplier then in effect as set forth in Appendix B hereto, which is by this reference incorporated herein.

(2) Option 2: This option allows an Eligible Retiree to receive an initial benefit level that is one and one half (1.5) times higher than the benefit level that the Retiree will receive starting the month after the Eligible Retiree attains age sixty-five (65).

(3) Option 3: This option allows an Eligible Retiree to receive an initial benefit level that is two (2) times higher than the benefit level that the Retiree will receive starting the month after the Eligible Retiree attains age sixty-five (65).

(4) Option 4: This option allows an Eligible Retiree to receive an initial benefit level that is three (3) times higher than the benefit level that the Retiree will receive starting the month after the Eligible Retiree attains age sixty-five (65).

Examples are set forth in Appendix D hereto, which by this reference is incorporated herein.

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

(c) Surviving Spouse. The benefit level for a Surviving Spouse shall be 50% of the benefit level of the Eligible Retiree. If the Eligible Retiree dies before making a selection among the benefit level options pursuant to subsection 3.2(a) hereof, the benefit level of the Surviving Spouse shall be 50% of the benefit level under Option 1 of the Eligible Retiree (currently determined in accordance with subsection 3.2(a)(1) hereof).

(d) Domestic Partner. Subject to subsection 3.2(f) hereof, the benefit level of a Domestic Partner will be the balance of the benefit level paid to the Retiree under subsection 3.2(a) hereof, minus related administrative expenses, after payment of the Retiree's Covered Expense(s).

(e) Surviving Domestic Partner. Subject to subsection 3.2(f) hereof, the benefit level for a Surviving Domestic Partner will be the equivalent of the Surviving Spouse benefit level. If the Eligible Retiree dies before making a selection among the benefit level options pursuant to subsection 3.2(a) hereof, the benefit level of the Surviving Domestic Partner shall be 50% of the benefit level of the Eligible Retiree (currently determined in accordance with subsection 3.2(a)(1) hereof)."

(f) Aggregate and Maximum for Domestic Partners and Surviving Domestic Partners. The aggregate amount paid to all Domestic Partners and Surviving

Domestic Partners under subsections 3.2(d) and 3.2(e) hereof annually shall not exceed the maximum amount allowed to Domestic Partners under federal tax law (currently set at 3% of the total benefits paid by the Plan annually), which shall be calculated within thirty days after the end of each Plan year. This limit shall apply to the total aggregate amount of benefits that will be paid to Eligible Retirees in the Plan who are Domestic Partners, and to their Surviving Domestic Partners.

(g) Surviving Children. If there is no Surviving Spouse or Surviving Domestic Partner, Surviving Children may receive the equivalent of the Surviving Spouse benefit, divided equally between or among the Surviving Children.

(h) Eligible Retiree with Short Service. There shall be no monthly limit on the benefit level for an Employee who becomes an Eligible Retiree pursuant to Section 2.1(e) (i.e., who does not earn five years of Active Service). Instead, such Eligible Retiree, and his or her Beneficiaries, shall be entitled to reimbursement for Covered Expenses at any time after separation from employment with a participating employer. The amount available to the Employee shall be limited to the amount of the total contributions submitted on his or her behalf, including mandatory transfer of sick and/or vacation leave (without any allocation for investment returns thereon). There shall be no monthly maximum amount on a claim so long as all claims are for reimbursement of Covered Expenses (*i.e.*, the benefit level calculated pursuant to Section 3.2(a) does not apply to benefits under this subsection).

A Surviving Spouse or Surviving Domestic Partner of an Eligible Retiree with short service shall be entitled to reimbursement of Covered Expenses following the death of the Eligible Retiree until the total amount of benefits available to the Eligible Retiree has been exhausted. If there is no Surviving Spouse or Surviving Domestic Partner, then the Surviving Children shall be entitled to reimbursement of Covered Expenses until the total amount of benefits available to the Eligible Retiree has been exhausted or the Surviving Children no longer meet the definition of Surviving Children set forth in Section 1.4 above, whichever occurs first.

(i) Delayed Commencement of Benefits. In the event an Eligible Retiree, who has earned five (5) years of Active Service at the time he or she attains age 53, defers commencement of all benefits from the Plan, the Plan will grant one additional year of Active Service for each year of deferral beyond age 53. For each full year of deferral, the Plan will grant to the Eligible Retiree additional Active Service Units in an amount equal to the average number of Active Service Units earned per year of Plan contributions during the Eligible Retiree's employment.

3.3 Commencement of Benefits.

(a) An Employee shall be entitled to benefits upon meeting the eligibility requirements of Article II. An Eligible Retiree who elects to delay commencement of benefits pursuant to Section 3.2(i) above, may elect to

commence benefits at any time during a subsequent Plan year.

(b) A Surviving Spouse shall be entitled to benefits starting the month after the death of the Eligible Retiree. If there is no Surviving Spouse or Surviving Domestic Partner, an Eligible Retiree's Surviving Child shall be entitled to receive monthly benefit payments equivalent to the Surviving Spouse benefit, divided equally between or among Surviving Children, starting the month after the death of the Eligible Retiree.

(c) Subject to Section 4.1, a Domestic Partner or Surviving Domestic Partner will commence receiving benefits within 60 days after the end of the Plan year in which Covered Expenses were incurred, pursuant to the calculation made in Section 3.2(f).

3.4 Termination of Benefits.

(a) Eligible Retirees. An Eligible Retiree's benefit coverage under the Plan shall terminate on the date of the Retiree's death. Claims for Covered Expenses incurred by the Retiree, which are properly and timely submitted on behalf of the deceased Retiree after death, will be paid for the months through and including the month in which the Retiree died, at the rate of the monthly benefit level for that Retiree.

(b) Surviving Spouse. A Surviving Spouse's benefit coverage under the Plan shall terminate on the first to occur of the following:

(1) The date the Spouse becomes eligible for Medicare, even if he or she does not adequately enroll in Medicare; or

(2) The date of the Surviving Spouse's death. Claims for Covered Expenses incurred by the Surviving Spouse, which are properly and timely submitted on behalf of the deceased Surviving Spouse after death, will be paid for the months through and including the month in which the Surviving Spouse died, at the rate of the monthly benefit level for the Surviving Spouse.

(c) Surviving Domestic Partner. Subject to Section 3.2(f) hereof, a Surviving Domestic Partner's benefit coverage under the Plan shall terminate on the first to occur of the following:

(1) The date the Domestic Partner becomes eligible for Medicare, even if he or she does not adequately enroll in Medicare; or

(2) The date of the Domestic Partner's death. Claims for Covered Expenses incurred by the Surviving Domestic Partner, which are properly and timely submitted on behalf of the deceased Surviving Domestic Partner after death, will be paid for the months through and including the month in which the Surviving Domestic Partner died, at the rate of the monthly

benefit level for the Surviving Domestic Partner, subject to Section 3.2(f) hereof.

(d) Surviving Children. If there is no Surviving Spouse or Surviving Domestic Partner, Surviving Children may receive the Surviving Spouse benefits, divided equally between or among the Surviving Children. The coverage under the Plan of Surviving Children shall terminate on the date of loss of Child status.

(e) Termination – General. Benefit coverage may be modified or terminated pursuant to Article VI hereof.

(f) Short Service Retirees. Reimbursement of Covered Expenses under Section 3.2 (h) will terminate when the amount available (as described in Section 3.2 (h)) reaches zero (due to reimbursement of Covered Expenses). Any balance remaining upon the death of the Retiree may be used for Surviving Spouse's, Surviving Domestic Partner's, or Surviving Children's Covered Expenses. Any balance remaining upon the death of the Surviving Spouse, Surviving Domestic Partner, or Surviving Children shall forfeit to the Plan.

3.5 Claim Procedure.

(a) To make a claim for Plan benefits, Beneficiaries must present independent third-party documentation of the following:

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

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

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

Along with the above documentation, Beneficiaries must submit a completed claim form, approved by the Trustees, to the Trust Office. Prior to issuing payment, the Trust Office shall review such documentation and claim form and determine whether to grant or deny coverage under the Plan. Documentation must be submitted for each claim, except that documentation of a recurring Covered Expense, under Section 1.8(a) or (c), must be submitted upon request, but no less frequently than annually.

The Trust Office may establish reasonable procedures and charge reasonable fees for processing benefit claims and Qualified Medical Child Support Orders and Qualified Domestic Relations Orders.

(b) Prior to issuing payment, the Trust Office shall review such proof and determine whether to grant or deny coverage under the Plan. Documentation of payment under subsection 3.5(a)(3) above shall include, but not be limited to, the

following, subject to Trust Office verification, as determined by the Trustees in their sole discretion:

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

(2) Copy of confirmation of electronic payment to the insurance provider or medical services or supplies provider; or

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

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

(d) If the Trust Office grants coverage, payment will be made to the Beneficiary. If the Trust Office denies coverage, the Beneficiary may appeal the denial of coverage or any other adverse benefit determination of the Trust Office under Section 4.3 hereof.

(e) Claims for Plan benefits must be submitted no later than March 31st of the following year from the date on which the Beneficiary made the payment of Covered Expenses. For example, all Covered Expenses for which the Beneficiary made payment in the year 2015 must be submitted for reimbursement no later than March 31, 2016. However, the Trust Office may waive the deadline for good cause shown, according to guidelines set by the Trustees. Subject to Subsection (g), below, unless specifically provided by law, the Trust Office shall not make any payments on behalf of or distributions to any person entitled to any benefits except to a Beneficiary personally or pursuant to a Qualified Domestic Relations Order or Qualified Medical Child Support Order under federal law.

(g) If a Beneficiary is deemed to be incompetent by a lawful judicial or quasi-judicial forum, then any payment due may be paid to such person and in such manner as the Trust Office, in its sole discretion, consider to be in the best interest of the Beneficiary (unless the judicial forum has appointed a party as the Beneficiary's representative, in which case the Trust Office will make payment to that party). The Trustees shall not be under any duty to oversee the application of funds so paid, provided due care was exercised in the selection of the person to whom funds were paid, and the receipt of the person to whom funds were paid shall be full acquittance to the Trustees. The Trust Office shall not be liable to any person for a determination made in good faith that a Beneficiary is incompetent.

(h) Nothing in this Agreement shall preclude a Beneficiary from appointing an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of an adverse benefit determination. The Beneficiary must submit such a request in writing to the Trust Office, who will then verify the appointment.

When a Beneficiary designates an authorized representative to act and receive notice on his or her behalf with respect to a claim, the Trust Office will, in the absence of a contrary direction from the Beneficiary, direct all information and notification to which the Beneficiary is otherwise entitled to the representative authorized to act on the Beneficiary's behalf with respect to that aspect of the claim.

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

ARTICLE IV
CLAIM APPEAL PROCEDURES

4.1 **Beneficiary's Duty to Notify Trust Office of Claim**. The Beneficiary is required to notify the Trust Office of his or her claim for benefits pursuant to Section 3.5 hereof, before he or she is entitled to either receive benefits under this Plan, or appeal a decision of the Trust Office denying a request for benefits.

4.2 **Acceptance or Denial of Claims by the Trust Office**.

(a) Standard Claim Decision - Timing. The Trust Office shall consider each claim for Plan benefits and determine whether to grant or deny coverage under the Plan. Subject to Sections 4.2(b) and 4.2(c) below, the Trust Office shall send written notification of its decision to the Beneficiary not later than thirty (30) days after receipt of the Beneficiary's claim. If coverage is granted, the Beneficiary shall receive payment as stated in Section 3.5(d). If the claim is denied, the Beneficiary has the right to appeal the claim, pursuant to Section 4.3 hereof and the Plan's "Appeal Procedures," if any, available from the Trust Office.

The denial notification shall include the following information:

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

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

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

(4) A description of any additional material or information necessary for the

Beneficiary to perfect the claim and an explanation of why such material or information is necessary;

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

(6) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits and a statement of the Beneficiary's right to bring an action under ERISA Section 502(a), after exhausting the Plan's appeal procedures.

(b) Extension of Time - Special Circumstances. If the Trust Office determines that special circumstances beyond its control require an extension of time for processing the claim, written notice of the extension shall be furnished to the Beneficiary prior to the termination of the initial thirty (30) day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trust Office expects to render a benefit determination. In no event shall such extension exceed a period of fifteen (15) days from the end of the initial period (45 days total).

(c) Extension of Time – Failure to Submit Information. The period of time for the Trust Office to make a benefit determination may be extended if the Beneficiary fails to submit all necessary information to allow the Trust Office to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Beneficiary until the date the Beneficiary provides to the Trust Office the requested information. The Beneficiary shall be allowed at least forty-five (45) days from receipt of the request for additional information within which to provide the information. Nothing in this Section shall preclude the Beneficiary from voluntarily agreeing to provide the Trust Office additional time within which to make a decision on a claim.

4.3 Appeal Procedures. Beneficiaries and any person who claims to be entitled to benefits under this Plan shall follow the provisions in this Article IV.

(a) Exclusive Procedures. The procedures specified in this Section, together with any written hearing procedures adopted by the Trustees, shall be the exclusive procedures available to a person dissatisfied with an eligibility determination, benefit claim decision or response to written request pursuant to Section 3.5(i) hereof, or to a person who is otherwise adversely affected by any action of the Trustees.

(b) Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in writing within one hundred eighty-one (181) calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes

that the grounds for denial of benefits are inapplicable. The Beneficiary may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for benefits to the Trustees. The Beneficiary shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Beneficiary's claim for benefits.

(c) Hearing Procedures. The Trustees shall conduct a hearing at the next regularly scheduled meeting of the Board of Trustees, unless the request for review is received by the Trustees within thirty (30) days preceding the date of such meeting. In such case, the hearing will be conducted no later than the date of the second meeting following the Trustees' receipt of the request for review. If special circumstances require a further extension of the time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of request for review. If such an extension of time for review is required because of special circumstances, the Trustees shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trustees will review all comments, documents, records and other information submitted by the Beneficiary related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Beneficiary shall be entitled to present his or her position and any evidence in support thereof at the hearing. The Beneficiary may be represented by an attorney or any other representative of his or her choosing at the Beneficiary's expense.

(d) Decision after Appeal Hearing. No later than five (5) days after the benefit determination related to the hearing is made, the Trustees shall notify the claimant of the determination on review by issuing a written decision, affirming, modifying or setting aside the former decision. Any notification of a denial of benefits shall include the following information:

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

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

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

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

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

(6) An explanation of the Beneficiary's right to bring an action in federal court under ERISA Section 502(a), after exhausting the Plans appeal procedures.

(e) External Review Process. The Trustees shall adopt an external review process that meets the minimum standards for such process established under Section 2719 of the Public Health Services Act (42 USC Section 300gg-19(b)). The Trustees will provide all Beneficiaries with notice of the availability of both the internal appeal hearing and the external review process.

4.4 Right to Court Review, Time Limit to Bring Lawsuit

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

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

ARTICLE V
MISCELLANEOUS

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

5.2 Applicable Laws and Regulations. Reference in this Plan to any particular sections of any local, state or federal statute shall include any regulation pertinent to such sections and any subsequent amendments to such sections or regulations. Except where this Plan is subject to Washington law, this Plan and the Fund shall be guided by ERISA.

5.3 Confidentiality. It is agreed and understood that each Beneficiary who applies for benefits under this Plan is entitled to the same rights and consideration, including the right of confidentiality, and the Trustees shall not be required to nor shall they reveal to any other persons, including the WSCFF, its officers, agents or employees, any matters revealed to them in confidence by such Beneficiary in the course of his or her application for benefits, except to the extent required by law.

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

the benefit plans, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision shall be binding and conclusive.

ARTICLE VI
AMENDMENTS AND TERMINATION

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

(a) To adjust the Unit Multiplier and benefit levels as to some or all current and/or future Beneficiaries.

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

(c) To terminate the Plan.

Amendments shall be made by action of the Board of Trustees pursuant to Article XIII of the Trust Agreement, and written notice shall be sent to the WSCFF within 30 days of the action.

APPENDIX A
Examples of Calculation of Benefit Level

These examples illustrate how to calculate the benefit level for an Eligible Retiree who elects Option 1 under the Plan, i.e., a benefit level that remains constant for the life of the Eligible Retiree. For examples of how to calculate the benefit level for an Eligible Retiree who selects one of the other options, see Appendix D. Please note that these are examples only - your monthly Contribution rate and length of participation may differ.

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

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

Step 1: Convert monthly contributions to Active Service Units.
$100/month = 4 Active Service Units/ Month
$150/month = 6 Active Service Units/ Month

Step 2: Find number Active Service Units.
4 Active Service Units x 24 months = 96 Active Service Units
6 Active Service Units x 48 months = 288 Active Service Units
Total = 384 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 384 x $0.41 = $157.44

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

Step 1: Convert monthly contribution to Active Service Units.
$100/month = 4 Active Service Units/ Month
$200/month = 8 Active Service Units/ Month

Step 2: Find number Active Service Units.
4 Active Service Units x 84 months = 336 Active Service Units
8 Active Service Units x 60 months = 480 Active Service Units
Total = 816 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 816 x $0.41 = $334.56

Example #3 – Career Employee – 25 years in Trust: A Local selects a contribution rate of $100/month, and Employee #3 participates for seven years (or 84 months) at that amount. Then the Local increases the contribution rate to $200/month, and Employee #3 participates for 18 years (or 216 months) at that amount, and then retires. Employee #3's monthly benefit level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly contributions to Active Service Units.
$100/month = 4 Active Service Units/ Month
$200/month = 8 Active Service Units/ Month

Step 2: Find number Active Service Units.
4 Active Service Units x 84 months = 336 Active Service Units
8 Active Service Units x 216 months = 1728 Active Service Units
Total = 2064 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 2064 x $0.41 = $846.24

***** **These** ***are examples. The Trustees reserve the right to modify the Unit Multiplier and the formula used to calculate benefit levels at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Plan. For more details, please contact the Trust Office: Benefit Solutions, Inc. (425) 771-7359.***

APPENDIX B
Chart of Unit Multiplier Value

Operative Date	Unit Multiplier (UM)
September 1, 2009	$0.42
July 1, 2012	$0.39
July 1, 2015	$0.41

The Trustees work with a professional actuarial firm to determine the UM. The Trustees have the authority to modify the UM from time to time for both existing and future Beneficiaries (see Section 3.2 of the Plan). The amount paid by the Trust may not exceed the actual Covered Expense(s) paid by the Beneficiary. The benefit level of an Eligible Retiree is generally determined using the Unit Multiplier in effect on or after the corresponding Operative Date.

APPENDIX C

Leave Conversion Table

Effective July 1, 2015

Section 2.2(b) of MERP sets forth the terms and conditions under which accumulated sick and/or vacation leave is converted into Active Service Units ("ASUs"). This table illustrates how many ASUs an Employee can earn when an employer transfers leave to the Trust (pursuant to a Collective Bargaining Agreement).

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

  Dollar amount transferred divided by the applicable cost as shown below for one ASU

- The cost for one ASU depends on a number of factors, including the age of the Employee at the time of the leave transfer, the current Unit Multiplier* (see Appendix B above), and other actuarial factors, as determined by the professional actuarial firm engaged by the Trustees.

- **This leave conversion table assumes a leave transfer of $1,000**. Note for comparison purposes that, each $25 monthly Contribution made during active employment gives an Employee one ASU. Thus, $1,000 in monthly Contributions would be equivalent to 40 ASUs.

- Note that you pay **no taxes** on leave that is transferred into MERP, and you pay **no taxes** on the money you receive as reimbursement from the Trust for "Covered Expenses."

Age at leave transfer	**Cost for One Active Service Unit ("x")**	**Number of ASUs Earned ($1,000 / x) (rounded to nearest whole number)**
Up to and through age 40	$26.02	38
Age 41	$27.84	36
Age 42	$29.79	34
Age 43	$31.88	31
Age 44	$34.11	29
Age 45	$36.49	27
Age 46	$39.05	26
Age 47	$41.78	24
Age 48	$44.71	22
Age 49	$47.84	21

Age 50	$51.19	20
Age 51	$54.77	18
Age 52	$58.60	17
Age 53	$62.70	16
Age 54	$62.10	16
Age 55	$61.46	16
Age 56	$60.79	16
Age 57	$60.09	17
Age 58	$59.36	17
Age 59	$58.59	17
Age 60	$57.78	17
Age 61	$56.94	18
Age 62	$56.06	18
Age 63	$55.15	18
Age 64	$54.20	18
Age 65	$53.22	19
Age 66	$52.21	19
Age 67	$51.16	20
Age 68	$50.09	20
Age 69	$48.98	20
Age 70	$47.84	21

***** *The Trustees work with a professional actuarial firm to determine the UM. The Trustees have the authority to modify the UM from time to time for both existing and future Beneficiaries.*

APPENDIX D

EXAMPLES OF CALCULATION OF BENEFIT LEVEL OPTIONS

Option 1: flat benefit level from retirement under MERP for lifetime*
Option 2: pre-65 benefit level is 1.5 times higher than post-65 benefit level
Option 3: pre-65 benefit level is 2 times higher than post-65 benefit level
Option 4: pre-65 benefit level is 3 times higher than post-65 benefit level

The benefit levels under Options 2, 3 and 4 depend on a participant's age when he or she retires. The following examples are for a participant who retires under MERP at age 55. Note that under MERP, a participant may retire as early as age 53.

To get the adjusted benefit level, you multiply the flat benefit level by the applicable actuarial factor from the Actuarial Factor Table below for an Eligible Retiree who is 55 years old.

Please note these are examples only – your actual benefit level may differ.

Example #1 – 6 years in MERP: Consider a 6-year participant whose monthly benefit level under Option 1 would be $157.44. Here are this participant's Options:

Option 1: $157.44 level benefit from retirement under MERP for lifetime*

Option 2: pre-65 benefit level = $157.44 x 1.163 = $183.10
post-65 benefit level = $157.44 x 0.775 = $122.02

Option 3: pre-65 benefit level = $157.44 x 1.266 = $199.32
post-65 benefit level = $157.44 x 0.633 = $99.66

Option 4: pre-65 benefit level = $157.44 x 1.389 = $218.68
post-65 benefit level = $157.44 x 0.463 = $72.89

Example #2 – 13 years in MERP: Consider a 13-year participant whose monthly benefit level under Option 1 would be is $334.56. Here are this participant's Options:

Option 1: $334.56 level benefit from retirement under MERP for lifetime*

Option 2: pre-65 benefit level = $334.56 x 1.163 = $389.10
post-65 benefit level = $334.56 x .775 = $259.28

Option 3: pre-65 benefit level = $334.56 x 1.266 = $423.55
post-65 benefit level = $334.56 x .633 = $211.78

Option 4: pre-65 benefit level = $334.56 x 1.389 = $464.70
Post-65 benefit level = $334.56 x .463 = $154.90

Example #3 – 25 years in MERP: Consider a 25-year participant whose monthly benefit level under Option 1 would be $846.24. Here are this participant's Options:

Option 1: $846.24 level benefit from retirement under MERP for lifetime*

Option 2: pre-65 benefit level = $846.24 x 1.163 = $984.18
post-65 benefit level = $846.24 x .775 = $655.84

Option 3: pre-65 benefit level = $846.24 x 1.266 = $1,071.34
post-65 benefit level = $846.24 x .633 = $535.67

Option 4: pre-65 benefit level = $846.24 x 1.389 = $1,175.43
post-65 benefit level = $846.24 x .463 = $391.81

Actuarial Factors Table

Age	Pre-65 Factor (1.5x)	Post-65 Factor (1.5x)	Pre-65 Factor (2x)	Post-65 Factor (2x)	Pre-65 Factor (3x)	Post-65 Factor 3(x)
53	1.136	0.757	1.218	0.609	1.314	0.438
55	**1.163**	**0.775**	**1.266**	**0.633**	**1.389**	**0.463**
57	1.197	0.798	1.328	0.664	1.491	0.497
59	1.242	0.828	1.414	0.707	1.638	0.546
61	1.302	0.868	1.532	0.766	1.863	0.621
63	1.383	0.922	1.710	0.855	2.241	0.747

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

SECTION III
COBRA GENERAL NOTICE

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

COBRA General Notice

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

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

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of his or her health premium or medical expense costs after separation from employment and attainment of the eligibility age (currently 53),[7] rather than health benefits insurance coverage for former employees of any age. That is, this Plan is for retiree reimbursement health care expenses, not insurance coverage.

1. COBRA Generally. You are a participant in the Medical Expense Reimbursement Plan (hereafter the "Plan") of the Washington State Council of Fire Fighters Employee Benefit Trust (hereafter the "Trust"), which provides reimbursement towards certain medical expenses, as defined in the Plan, after reaching the eligibility age and other eligibility requirements. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[8]

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUTIONS UNDER COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE

[7] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay reimbursements for premiums or medical expenses to terminated Employees until attainment of age 53, and the COBRA right entitles the Qualified Beneficiary to self-pay contributions to earn additional Active Service and Active Service Units.
[8] Public Law 99-272, Title X

COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

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

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

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

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

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

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

B. Plan Eligibility Requirements. To be eligible to receive these monthly medical expense reimbursement benefits after attaining eligibility age, this Plan requires that the Employee earn five (5) years of Active Service as defined in Section 2.2 of the Plan. Therefore, making COBRA self-payments could enable you to meet the Active Service requirement and become eligible for monthly benefits, depending on how many years of Active Service you have earned at the time of the Qualifying Event.

Further, since the Plan also provides for a gradually increasing level of benefits based on the amount of your contributions, you may be able to increase your monthly benefit level

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

if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7** below. Finally, if you cannot become eligible for the monthly lifetime benefits, you will be eligible for short service benefits under Section 3.2(h) of the Plan, which you can access upon separation from employment. (Note that if you make COBRA self-payments under this circumstance, you might be making contributions at the same time you are receiving benefits under Section 3.2(h) of the Plan.)

C. Consequence of Non-Election. If you do not choose to continue contributing to this Plan and have not earned five (5) years of Active Service, you will not qualify for monthly benefits as a Regular Beneficiary. Instead, you will be eligible to receive benefits limited to the total contributions submitted on your behalf (including mandatory leave transfers) in accordance with Section 3.2(h) of the Plan.

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

3. Qualifying Events and Qualified Beneficiaries.

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

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

ii) Reduction of Work Hours. Your hours of employment are reduced.

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

B. The Spouse as a Qualified Beneficiary. If you are the spouse of an Employee covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Trust on your spouse's behalf cease due to any of the following "Qualifying Events,"[10] and provided that the Employee does not elect to self-pay contributions under COBRA*:

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

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

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

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

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

C. A Child as a Qualified Beneficiary. If you are a Child of an Employee covered by this Plan, and neither of your parents elects to self-pay contributions under COBRA, you may become a Qualified Beneficiary and have rights to self-pay contribution to this Plan if contributions to the Trust on your parent's behalf cease due to any of the following Qualifying Events, and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

ii) Death of Parent. The death of the parent who is the Employee; or

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

iv) Reduction of Parent's Work Hours. A reduction in hours of employment of the Employee parent, where neither the employee parent nor spouse elect to self-pay contributions under COBRA.[4]

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

4. Notification of Qualifying Event.

A. Employer's Notification Responsibility. The Plan will offer the COBRA option to self-pay contributions to Qualified Beneficiaries only after the Trust Office has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** must notify the Trust Office of the Qualifying Event.

[4] Under some plans, a child losing Child status under the plan would be a Qualifying Event, but because of the plan design of this Plan, this event is not a Qualifying Event under this Plan.

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

i) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to self-pay contributions under COBRA for a maximum period of eighteen (18) months (or twenty-nine (29) months in the case of a disability, as described in Section 6 below); or

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

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

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

i) Qualifying Events Other Than Disability. If a second Qualifying Event occurs, the Employee or other Qualified Beneficiary must notify the Trust Office no later than sixty (60) days after the latest of:

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

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

c) *The Date you Receive Notice.* The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 below).

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

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

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

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

d) *The Date you Receive Notice.* The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

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

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

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

5. Procedures for Notifying Plan of Qualifying Event. Subject to the time limits in **Section 4(C)** above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s), described in **Section 4(B)** above, to the Trust Office by either first class mail or facsimile (fax) or email. The contact information for the Trust Office is as follows:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: 425-771-7359
Fax: 866-601-4397
Email: wscffmerp@bsitpa.com

The notice of the Qualifying Event should include:

A. Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

B. Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

C. Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

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

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

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

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

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

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

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

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

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

A. The Trust no longer maintains the Plan; or

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

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

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

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

8. Refund of Contributions Erroneously Paid. Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Trust Office and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to self-pay contributions. Any Active Service or Active Service Units granted based on an erroneous contribution will be rescinded or returned, as the case may be.

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

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 771-7359
Email: wscffmerp@bsitpa.com

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

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

SECTION IV

HIPAA NOTICE OF PRIVACY PRACTICES

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

NOTICE OF PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION

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

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

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

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

II. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**: Except with respect to uses or disclosures of PHI that require an authorization as described in Section IV of this Notice, we may use or disclose protected health information for purposes of treatment, payment, or health care operations, as set forth in Paragraphs II.A – II.D below, without your consent. We may elect to obtain your consent to use or disclose protected health information for such purposes, although we are not required to do so. Moreover, such consent shall not be effective to permit a use or disclosure of protected health care information that requires an authorization as described in Section IV of this Notice.

A. Uses and Disclosures for Payment of Medical Expense and Premium Reimbursement Claims. "Payment" includes, but is not limited to, actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to medical expense or premium reimbursement.

B. Uses and Disclosures for the Payment Activities of Another "Covered Entity." PHI may be shared with other "covered entities," which include health care providers and health plans, in certain circumstances. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. Disclosures to Another Covered Entity for Health Care Fraud and Abuse Detection or Compliance or Health Care Operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and to perform related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains, and the information disclosed pertains to that relationship.

D. Disclosures to the Board of Trustees of the Trust, as the Plan Fiduciary, as Necessary for Trust Administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

III. **Other Uses and Disclosures Permitted or Required Without Authorization**: We may, by complying with the requirements specified in the Privacy Rule, use or disclose protected health information without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

A. When and to the extent such use or disclosure is required by law.

B For public health activities or public health oversight authorized by law.

C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.

E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, or reporting crime in emergencies; or if the information constitutes evidence of criminal conduct on our premises.

F. For coroners, medical examiners, and funeral directors to perform their legal duties.

G. For procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

H. For research purposes, where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.

J. For specialized government functions related to military personnel, veteran's benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.

K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.

L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information, if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

IV. **Authorization Required for Other Uses and Disclosures**: Uses and disclosures of protected health information other than those identified above will be made only with your written authorization. You may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or contest the policy itself.

V. **Individual Rights**: All participants have the following rights with respect to protected health information that the Plan maintains about them:

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

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

B. **Confidential Communications**. We must accommodate reasonable requests to have protected health information communicated to you in confidence by alternative means or at alternative locations. We may require your request to be in writing, to state (if appropriate) how payment for the accommodation will be handled, to specify an alternative method of contacting you, or to state that disclosure of all or part of the protected health information could endanger you.

C. **Access for Inspection and Copying**: You may request access to inspect or copy protected health information that is maintained about you in a designated record set. If we grant your request we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and the costs to which you have agreed in advance for preparing an explanation or summary. If we deny

your request, in whole or in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other protected health information subject to your request.

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

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

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

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

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

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

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

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

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Benefit Solutions, Inc.
Attn: Privacy Contact Person
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 771-7359
Email: wscffmerp@bsitpa.com

B. **Privacy Complaints.** You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Person or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

C. **No Intimidation or Retaliation.** No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a Privacy Complaint.

VIII. **Effective Date**: This notice shall become effective on July 6, 2015, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI.

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

From: BOARD OF TRUSTEES
WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST
Privacy Contact Person phone number: (425) 771-7359