MEDICAL EXPENSE REIMBURSEMENT PLAN

OF THE

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

Plan effective date: August 1, 2014

(4/10/14 Ed., incl. Am. Nos. 1-7.)
PREAMBLE

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

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

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

WHEREAS, the Board of Trustees of the aforementioned Trust adopted the Medical Expense Reimbursement Program of the Health Professionals and Allied Employees, AFT/AFL-CIO, Retiree Medical Trust, effective January 1, 2007, and thereafter amended the Plan document seven times (Program Amendment Nos. 1-7), and now wishes to integrate the Amendments into the Plan document and to amend the Plan to adopt a new benefit structure based on Active Service Units;

NOW THEREFORE, the Board of Trustees does hereby adopt this Medical Expense Reimbursement Plan of the Health Professionals and Allied Employees, AFT/AFL-CIO, Retiree Medical Trust, which includes Program Amendments Nos. 1-7, and further changes, restated effective August 1, 2014.

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 meanings are apparent from the context.

1.1(a) “Active Service” means service as defined in Section 2.2 hereof, after the Employee’s Effective Date. Effective for an Employee with one contribution to the Trust on or after August 1, 2014, the Trust will grant one year of Active Service for any calendar year in which the employee has 850 contributory hours in the Trust. Active Service is a factor used to determine eligibility as a Regular Beneficiary under Section 2.1(a) hereof.

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

1.2 “Beneficiary” means any person eligible to receive benefits as a Regular Beneficiary or Limited Beneficiary, his or her lawful spouse or Domestic Partner and Children; and the Surviving Spouse, Surviving Domestic Partner, and Surviving Children of a Regular Beneficiary or Limited Beneficiary. A “Regular Beneficiary” is a person who has become eligible for monthly benefits under Section 2.1(a). A “Limited Beneficiary” is a person who has become eligible for benefits from an Employee Account under Section 2.1(b).

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

1.4 “Child(ren)” means a natural child or lawfully adopted child of the Employee, Regular Beneficiary or Limited Beneficiary, or child placed in the home of the Employee, Regular Beneficiary or Limited Beneficiary for adoption by the Employee, Regular Beneficiary or Limited Beneficiary, who either: (a) is under the age of 26; or (b) is legally dependent upon the Regular Beneficiary, Limited Beneficiary or Employee for support and maintenance, for so long as the child is determined to be totally disabled by the Social Security Administration.

“Surviving Child(ren)” means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Beneficiary’s death and who continues to meet that definition.

1.5 “Code” means the Internal Revenue Code, as amended.

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

1.7 “Contribution” means a mandatory transfer to the Trust made by or on behalf of all employees in a specific classification within a bargaining unit represented by a Local, pursuant to a Collective Bargaining Agreement between a Participating Employer and a Local. (a) Except for sick leave transfers, contributions shall be made at the level of at least $0.10/hour worked, or such higher amount as is divisible by $0.05. (b) Contributions made prior to August 1, 2014, shall be converted, according to rules set by the Trustees, into Active Service Units for purposes of determining a Regular Beneficiary’s monthly benefit level under Section 3.3(a) hereof. (c) All Contributions must be made without any election on the part of an individual employee (except for contributions made pursuant to continuation requirements of
federal law under IRC Sec. 4980B). Any elective contributions (other than under 4980B) will be returned within thirty (30) days of discovery that the contribution was made by individual election, and Active Service Units granted based on an elective contribution will be rescinded.

1.8 “Covered Expense” means the following:

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

(b) medical expenses, as defined in Code Section 213(d), (i.e., costs for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury), including insulin but excluding all other non-prescribed drugs, incurred by a 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) premium payment for long-term care insurance, qualified under Code Sec. 7702B, for coverage of a Beneficiary in effect while the Beneficiary is eligible for benefits under the Plan, but for no other expenses associated with the costs of long-term care.

1.9 “Domestic Partner” means a person who has met the criteria used to establish whether a person is a domestic partner under the rules of the Domestic Partner Act of New Jersey.

1.10 “Effective Date” for an Employee means the date that Contributions for that Employee’s Local are required and made to the Trust on behalf of the Employee, as approved by the Trustees.

1.11 “Employee” means an individual while employed by a participating employer; who is a member of a bargaining unit represented by a Local; and on whom the required contributions are made to the Trust pursuant to a Collective Bargaining Agreement for all periods of Active Service after the Effective Date.

1.12 “Employee Account” means the individual bookkeeping account maintained by the Trust in the name of an Employee, which reflects certain contributions made to the Trust as set forth in Section 3.5.

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

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

1.15 “Modify” means to adjust, including increase or decrease.
1.16 "Operative Period" means the period during which the corresponding Unit Multiplier is effective; the Unit Multiplier used to calculate the Benefit Level for a Regular Beneficiary is effective for claims paid by the Trust Office during the Operative Period of the Unit Multiplier. See the Appendix to the Plan.

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

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

1.19 "Surviving Spouse" or "Surviving Domestic Partner" means the lawful spouse, as defined in the Internal Revenue Code, or Domestic Partner of a Regular Beneficiary or Limited Beneficiary, who was in that status at least 12 months on the date of the death of the Regular Beneficiary or Limited Beneficiary. The Surviving Spouse or Surviving Domestic Partner of an Employee who has satisfied all the requirements of Section 2.1, except the Employee dies prior to separation from service, shall also be considered a Surviving Spouse or Surviving Domestic Partner.

1.20 "Trust" or "Trust Fund" means the Health Professionals and Allied Employees Retiree Medical Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records. "Trust Office" means Benserco Inc., 140 Sylvan Avenue, Ste. 303, Englewood Cliffs, NJ 07632; Phone: 201-947-8000; Fax: 201-947-9192.

1.21 "Trust Agreement" or "Agreement" means the Trust Agreement governing the Health Professionals and Allied Employees AFT/AFL-CIO Retiree Medical Trust, effective July 1, 2006, and any amendments hereto.

1.22 "Unit Multiplier" or "UM" means the variable amount periodically set by the Trustees, based on demographic and financial factors, and used in the determination of the monthly benefit level of a Regular Beneficiary, as set forth in section 3.3(a). The Trustees may adjust the UM from time to time.

ARTICLE II
ENTITLEMENT TO BENEFITS

2.1 Eligibility

(a) Eligibility as a Regular Beneficiary. An Employee shall become a Regular Beneficiary entitled to monthly benefits under Section 3.3 hereof when he or she meets the following requirements.
(1) Earns five (5) years of Active Service after the Employee’s Effective Date;

(2) Has terminated from all employment (excluding per diem employment for which no Contributions are made to this Plan) with his or her Participating Employer; and

(3) Attains age 55.

(b) Eligibility as a Limited Beneficiary. An Employee who separates from employment with a Participating Employer prior to earning five years of Active Service is a “Limited Beneficiary” under this Plan. A Limited Beneficiary is entitled to receive benefits from his or her individual Employee Account pursuant to Section 3.5 of this Plan when he or she terminates from all employment (excluding per diem employment for which no Contributions are made to this Plan) with his or her Participating Employer and meets one of the following requirements:

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

(2) The Employee has attained age 55; or

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

(c) Limited Beneficiaries: Credits to Employee Accounts. An Employee who becomes a Limited Beneficiary pursuant to Section 2.1(b) shall have contributions credited to his or her Employee Account according to the following rules:

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

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

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

b. The Employee was unable to complete five years of Active Service with the Participating Employer because of a disability, and the Employee received a Social Security determination of disability.
(3) **Sick Leave Transfers.** The amount of sick leave transfers will be credited to the Employee Account.

### 2.2 Active Service

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

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

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

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

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

(c) **Spouse or Child Contribution after Death of Employee (COBRA).** After the death of an Employee, a Surviving Spouse, Surviving Domestic Partner, or Surviving Child may continue to earn Active Service by periodic self-payment of contributions, for a maximum of thirty-six months, pursuant to the federal law known as COBRA, and rules set by the Trustees.

### 2.3 Self-Pay Contributions.

Self-payment rules for purposes of Section 2.2(b)-(c) shall be set by the Trustees and may be obtained from the Trust Office.

### 2.4 No Rebate or Refund.

Employees and/or Beneficiaries shall not be eligible for rebates or refunds of any contributions made, except as reimbursement of Covered Expenses; provided, however, that any elective contributions made (other than pursuant to the federal COBRA law) will be returned within thirty days of discovery that the contribution was made by individual election, and Active Service granted based on elective contributions will be rescinded.
ARTICLE III
BENEFITS

3.1 General. An Employee may become a Beneficiary under either Section 2.1(a) or 2.1(b) or both. The rules in Sections 3.3 and 3.4 apply to Regular Beneficiaries, i.e., those Employees who become eligible under Section 2.1(a). The rules in Section 3.5 apply to Limited Beneficiaries, i.e., those Employees who become eligible under Section 2.1(b) for benefits from Employee Accounts. All benefit payments are subject to proper and timely submission of claims pursuant to Sec. 3.6 hereof.

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

(a) Regular Beneficiary or Limited Beneficiary. A Regular Beneficiary or Limited Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(a) or 2.1(b) respectively.

(b) Surviving Spouse. A Surviving Spouse or Domestic Partner of a Regular Beneficiary or Limited Beneficiary shall be entitled to benefit payments starting the later of: (i) the month after the Regular Beneficiary or Limited Beneficiary dies; or (ii) the month that a deceased Regular Beneficiary or Limited Beneficiary would have attained age 55 (subject to Section 3.3(c)).

(c) Surviving Domestic Partner. A Surviving Domestic Partner will receive monthly benefit payments within 60 calendar days after the end of the Plan Year determined under Section 3.3(d) hereof, pursuant to the calculation set forth in 3.3(b).

(d) Surviving Children. If there is no Surviving Spouse or surviving Domestic Partner, surviving Child(ren) shall be entitled to receive monthly benefit payments upon death of the Employee.

3.3 Benefit Levels for Regular Beneficiaries. An Employee who becomes a Regular Beneficiary under Section 2.1(a), and his or her Surviving Spouse and Children, shall be entitled to monthly reimbursement of Covered Expenses incurred on or after August 1, 2014, in an amount not to exceed the Regular Beneficiary’s benefit level, calculated pursuant to this section.

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

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

(2) Multiply the number of Active Service Units by the Unit Multiplier in effect on the date that the Trust Office pays the claim of the Regular Beneficiary, subject to subsection 3.3(b) hereof.
(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 A hereto, which is by this reference incorporated herein.

(c) **Surviving Spouses and Children.** The benefit level for a Surviving Spouse (with or without surviving Children) shall be 50% of the benefit level for the Regular Beneficiary. If there is no Surviving Spouse or Domestic Partner and there are surviving Children, the benefit level shall be 50% of the benefit level for the Regular Beneficiary (to be divided equally among the Children). If a Regular Beneficiary has accumulated unused benefit amounts pursuant to Section 3.3(e) hereof, then the Surviving Spouse or Domestic Partner shall be entitled to such amounts. If there is no Surviving Spouse or Domestic Partner, then the surviving Children shall be entitled to such amounts (to be divided equally among the Children).

(d) **Domestic Partners**

(1) The benefit level for a Surviving Domestic Partner shall be the same as for a Surviving Spouse, subject to subsection (2) hereof.

(2) The aggregate amount paid to all Domestic Partners annually shall not exceed the maximum amount allowed to Domestic Partners under federal tax law (currently set at 3% of the total benefits paid annually), which shall be calculated within thirty calendar days after the end of each Plan year.

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

(f) **Carry Over of Claims that Exceed the Monthly Benefit Level Amount.** The Trust will carry over claim amounts for Covered Expenses that exceed the monthly Benefit Level of a Regular Beneficiary, provided, however, that the Trust will not prepay claims. For example, if a Regular Beneficiary has a monthly benefit level of $100 and submits a claim for Covered Expenses of $300 in January 2014, then the Trust will reimburse the Beneficiary $100 in January of 2014, $100 in February of 2014 and $100 in March of 2014, i.e., the Trust will not reimburse the Beneficiary $300 in January. (However, if there are new claims in February or March, payment on them will be deferred to April and carried over to subsequent months, as necessary).

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

(a) **Regular Beneficiary.** The monthly benefit coverage for a Regular Beneficiary under the Plan shall terminate on the earliest of the following dates:
(1) Return to employment with a Participating Employer; provided however that upon subsequent cessation of all employment with participating employers, benefit payments shall resume. This provision does not apply to per diem employment for which no Contributions are made to this Plan.

(2) Date of death of the Regular Beneficiary; provided however that claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Beneficiary after death, will be paid for the months through and including the month in which the Beneficiary died, at the rate of the monthly benefit level for that Beneficiary.

(b) Surviving Spouse, Domestic Partner, and Children. The monthly benefit coverage of the Child of a Regular Beneficiary under the Plan shall terminate as follows.

(1) Surviving Spouse or Domestic Partner. Claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Surviving Spouse or Domestic Partner after death, will be paid for the months through and including the month in which the Surviving Spouse or Domestic Partner died, at the rate of the monthly benefit level for that Surviving Spouse or Domestic Partner.

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

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

3.5 Benefits from Employee Accounts

(a) Employee Account Balance. An Employee who becomes a Limited Beneficiary under Section 2.1(b) hereof, and his or her Beneficiaries, are entitled to reimbursement of Covered Expenses from his or her Employee Account. After deductions for any benefit payments, the balance in the Employee Account shall include any remaining portions of Employee and Employer Contributions credited to an Employee Account, according to the rules of Section 2.1(c) herein, for an Employee who meets the description in Section 2.1(b) herein.

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

(c) Termination of Benefits from Employee Account. Reimbursement from the Employee Account will terminate when the Account balance reaches zero. Any balance left in the Employee Account upon the death of the Beneficiary and his or her surviving Beneficiaries will forfeit to the Plan.
3.6 Benefit Claim Procedure

(a) To make a claim for Plan benefits, Beneficiaries must present proof of payment of Covered Expenses, on a form approved by the Trustees, to:

Health Professionals and Allied Employees, AFT/AFL-CIO
Retiree Medical Trust
c/o Benserco, Inc.
140 Sylvan Avenue, Ste. 303
Englewood Cliffs, NJ 07632
Phone: (201) 947-8000 Fax: (201) 947-9192

Prior to issuing payment, the Trust Office shall review such proof and determine whether to grant or deny coverage under the Plan.

(b) 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 Trustees.

(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) Proof of payment of a covered expense shall include, but not be limited to, canceled checks drawn to the name of the medical insurance provider or receipt for payment from the medical insurance provider, subject to verification as determined by the Trustees in their sole discretion.

(e) Claims for Plan benefits should be submitted within 30 days after end of the Plan year in which the expense was paid. However, the Trust Office may waive the deadline for good cause shown, according to guidelines set by the Trustees.

(f) Subject to subsection (g), below, unless specifically provided by law, the Trustees 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 Medical Child Support Order under federal law.

(g) If a Beneficiary is deemed to be incompetent by a lawful judicial or quasi-judicial forum, or reasonably deemed to be incompetent by the Trustees, then any payment due may be paid to such person and in such manner as the Trustees, in their 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 Trustees 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 Trustees shall not be liable to any person for a determination made in good faith that a Beneficiary is incompetent.

(h) 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 Article III hereof, before he or she is entitled to either receive benefits under this Plan, or appeal the Trust Office’s decision denying a request for benefits.

4.2 Acceptance or Denial of Claims by the Trust Office

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

The denial notification shall include the following information:

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

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

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

(4) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request;
(5) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary’s claim for benefits; and

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

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

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

4.3 Appeal Procedures. The Trustees, Beneficiaries, and any person who claims to be entitled to benefits under this Plan shall follow the provisions 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 3.6(h) hereof, or to a person who is otherwise adversely affected by any action of the Trustees.

(b) Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in writing within 181 calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes that the grounds for denial of benefits are inapplicable. The Beneficiary may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for benefits to the Trustees. The Beneficiary shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Beneficiary’s claim for benefits.
(c) **Decision on Appeal.** The Trustees shall make decision, affirming, modifying or setting aside the former decision, no later than the date of the meeting of the Board of Trustees that immediately follows the Trust Office’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, the Trustees shall make a decision no later than the date of the second meeting following the Trust Office’s receipt of a request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be made not later than the third meeting of the Trustees following the Trust Office’s receipt of the request for review, provided that the Trust Office provides the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trust Office shall notify the claimant of the decision on appeal as soon as possible, but not later than 5 days after the benefit determination is made. The Trustees may issue a written decision within thirty days thereafter, unless special circumstances require another thirty day extension. Any notification of a denial of benefits shall include the following information:

1. The specific reason(s) for such denial;
2. Specific reference to the Plan provisions upon which the denial is based;
3. A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary’s claim for benefits;
4. A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request;
5. An explanation of the Beneficiary’s right to bring an action in federal court, after exhaustion of the Plan’s administrative procedures; and
6. The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

(d) **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)), as applicable. 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(h) 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 any Local, the HPAE or its employees, any Employer or its employees, the Trust or its employees, the Trust Office or the Trustees, except as provided in this Plan and the Trust Agreement.

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

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

5.4 Trustee Authority. The Trustees shall have the authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of this Trust and Plan, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees’ decision shall be binding and conclusive.

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 and applicable law, a Plan dedicated to providing benefits for Beneficiaries, the Trustees expressly reserve the right, in their sole discretion, at any time and from time to time, provided that such action does not violate federal discrimination law:
Medical Expense Reimbursement Plan
HPAE Retiree Medical Trust

(a) To modify the Benefit Amounts.

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

(c) To terminate the Plan.

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

Adopted this 7th date of April, 2014; and effective August 1, 2014.

FOR THE BOARD OF TRUSTEES,
HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO
RETIREE MEDICAL TRUST

Mike Slott
Chairman, Board of Trustees

Christine O’Hearn
Trustee

Joan Johnson
Trustee
APPENDIX A
UNIT MULTIPLIER

<table>
<thead>
<tr>
<th>Operative Period</th>
<th>Unit Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 2014 – present</td>
<td>$0.07</td>
</tr>
</tbody>
</table>

The Unit Multiplier (UM) is a factor in the calculation of the monthly benefit level for a Regular Beneficiary (see Section 3.3 of the Plan). The UM applies to claims for Covered Expenses submitted by Regular Beneficiaries, which the Trust Office pays during the corresponding Operative Period; provided, however, that the Trustees may modify the UM from time to time. Also, the actual amount paid by the Trust may not exceed the actual Covered Expenses paid by the Beneficiary.
APPENDIX B
EXAMPLES OF BENEFIT LEVEL CALCULATION

Every $5.00 contribution = 1 Active Service Unit
Assume Unit Multiplier= $0.07 (effective August 1, 2014)

Example #1 – 6 years in Trust: Assume a Local has a contribution rate of $0.20/hour worked, and Employee Jones works 2,000 hours per year (approximately 38.5 hours a week) for two years with that contribution rate. Then the Local increases the contribution rate to $0.25/hour worked, and Jones works 2,000 hours per year for four more years with that contribution rate, and then retires. The monthly amount available to Jones for medical expense reimbursement will be calculated as follows:

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

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

Step 3: Multiply number Active Service Units by Unit Multiplier.
- **Monthly Benefit Level**: 560 x $0.07 = $39.20
- **Annual Benefit**: $470.40

Example #2 – 12 years in Trust: A Local selects a contribution rate of $0.20/hour, and Employee Jones works 1,800 hours per year (approximately 34.6 hours a week) for seven years with that contribution rate. Then the Local increases the contribution rate to $0.40/hour, and Jones works 1,800 hours per year for five years at that level, and then retires. The monthly amount available to Jones for medical expense reimbursement will be calculated as follows:

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

Step 2: Find total number of Active Service Units (ASUs) earned
- 1/25 ASU/hour x 1,800 hours/year x 7 years = 504 ASUs
- 2/25 ASU/hour x 1,800 hours/year x 5 years = 720 ASUs
Total = 1224 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
- **Monthly Benefit Level**: 1224 x $0.07 = $85.68
- **Annual Benefit**: $1028.16
Example #3 – Career Employee – 25 years in Trust:  A Local selects a contribution rate of $0.20/hour, and Employee Jones works 1,800 hours per year (approximately 34.6 hours a week) for seven years with that contribution rate. Then the Local increases the contribution rate to $0.40/hour, and Jones works 1,800 hours per year for 18 years at that level, and then retires. The monthly amount available to Jones for medical reimbursement will be calculated as follows:

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

Step 2: Find total number of Active Service Units (ASUs) earned
1/25 ASU/hour x 1,800 hours/year x 7 years = 504 ASUs
2/25 ASU/hour x 1,800 hours/year x 18 years = 2592 ASUs
Total = 3096 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level:  3096 x $ 0.07 = $ 216.72
Annual Benefit: $2600.64

* * *

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

LEAVE CONVERSION TABLE

For Employees who convert Leave Transfer on and after October 1, 2016, the effective date of the Leave Conversion Tables is October 1, 2016.

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

- The number of ASUs an Employee earns as a result of the transfer of leave is calculated by the following formula:
  
  \[
  \frac{\text{Dollar amount transferred}}{\text{applicable cost for one ASU}}
  \]

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

- This leave conversion table assumes a leave transfer of $1,000.

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<tr>
<th>Age at Leave Transfer</th>
<th>Cost for One Active Service Unit in dollars and cents (“x”)</th>
<th>Number of ASUs Earned with $1000 ($1,000 / x) (rounded to nearest whole number)</th>
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