

**SUMMARY PLAN DESCRIPTION AND
MEDICAL EXPENSE REIMBURSEMENT PLAN
OF THE PORAC RETIREE MEDICAL TRUST**

Effective September 1, 2008

**SUMMARY PLAN DESCRIPTION AND MEDICAL
EXPENSE REIMBURSEMENT PLAN OF THE
PORAC RETIREE MEDICAL TRUST**

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**MEDICAL EXPENSE REIMBURSEMENT PLAN of the
PORAC RETIREE MEDICAL TRUST**

Summary Plan Description

HIGHLIGHTS OF THE PLAN:

- **Eligibility.** Generally, current employees will need 10 years in the Plan to achieve eligibility for benefits from the Trust (provided however, that for members close to retirement, this requirement is five years).
- **Benefits.** Your benefits from this Trust come in the form of reimbursement for certain medical costs, which are considered Covered Expenses¹ incurred after you retire. Your reimbursement amount is 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, within 30 days after the end of the plan year in which you incurred the expense.
- **Change of Address, Spouse or Dependent.** 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 spouse or dependents. Failure to notify the Trust Office may result in loss or delay of benefit payments.
- **Trust Office.** The Trust Office is a great 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:

PORAC Retiree Medical Trust c/o
Delta Health Systems Attn: Ms.
Cindi Forbes 555 W. Benjamin Holt
Dr., Ste. 320 Stockton, CA 95207
Phone: (800) 700-6762 Fax: (209)
955-4190

IMPORTANT NOTE: The questions and answers in the Summary Plan Description ("SPD"), published on this PORAC website, have been designed to provide you with key information about the PORAC Retiree Medical Trust, but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Medical Expense Reimbursement Plan of the PORAC Retiree Medical Trust" effective September 1, 2008 and as amended from time to time thereafter. If there is a conflict between what is contained in the Plan and what is contained in the Summary Plan Description that is published on this website or any other descriptions, the terms of the Plan will prevail. Capitalized terms contained in the SPD are defined in the formal Plan Document. Note that this SPD reflects Plan provisions as of November 1, 2008. The Trustees have the power to modify the Plan and you may check with the Trust Office for the latest amendments to the Plan.

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MEDICAL TRUST Summary Plan Description TABLE OF QUESTIONS**

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SUMMARY PLAN DESCRIPTION

1. Who can participate? Eligibility in the Plan is generally open to all permanent employees who are members of a bargaining unit represented by a participating Association and for whom contributions are made to the Trust as required by the MOU.

2. Who is eligible for benefits? An Employee described in Answer #1 becomes a Regular Beneficiary entitled to benefits under the Plan, generally, after the Employee meets the following requirements:

- Earns ten years of Active Service in the Trust (i.e., ten years of contributions to the Trust). However, if a person is already an Employee when his/her Association joins the Trust, the requirement is five years.
- Makes contributions to the Trust for all years of Active Service.
- Attains age 55 if a sworn public safety employee, and 58 if a non-sworn Employee.
- Ceases employment with a participating employer.

A Regular Beneficiary is entitled to a lifetime stream of monthly benefit payments at his/her benefit level, for reimbursement of medical expenses. See Sections 3.2 – 3.3 of the Plan for details.

3. What happens if I separate from service before I contribute to the Trust for 10 years (or five years for employees close to retirement when they join the Trust)? If an Employee does not earn the ten years (or five years, if applicable) of Active Service necessary to become a Regular Beneficiary, that Employee is classified as a Limited Beneficiary. Instead of receiving a lifetime stream of monthly reimbursement payments, the Trust will pay out reimbursements to the amount of contributions made by that Employee to the Trust over his/her career. That is, the contributions of a Limited Beneficiary will be held in Trust in his or her Employee Account. The Limited Beneficiary may draw on that account for the reimbursement of Covered Expenses. There is no monthly limit on benefit for a Limited Beneficiary, as long as all claims are for reimbursement of Covered Expenses. Benefits cease when the account balance reaches zero.

Note that a Regular Beneficiary may also have an Employee Account, which holds transfers of sick leave payout.

See Sections 2.1(b) and 3.5 of the Plan for details.

4. What are the benefits from the Trust? After meeting the eligibility requirements, both Regular Beneficiaries and Limited Beneficiaries are entitled to reimbursement toward the payment of Covered Expenses, which consist of insurance premiums and medical expenses paid by the Employee after the Employee retires and becomes eligible for benefits under the Plan. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment is limited to the Beneficiary's benefit level (for a Regular Beneficiary) or the balance in his/her Employee Account (for a Limited Beneficiary).

Cost Sharing. Also, it is important to remember that the Plan reimburses toward the cost of Covered Expenses, but your benefit level may not cover the entire Covered Expense amount. 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 amounts you owe in excess your benefit level.

5. What type of medical expenses will be reimbursed by the Plan? The following medical expenses are considered Covered Expenses and will be reimbursed by the Plan:

- Premium or contribution payments for coverage under health, dental, or visions insurance plans, for types of medical expenses excludable from gross income under Internal Revenue Service Code ("Code") Section 105(b).
- Medical expenses excludable from gross income under Code Section 213(d), i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury.
- Premium payment for long-term care insurance qualified under Code Section 7702.

See Plan Section 1.7 for a full definition of Covered Expenses.

6. How is my monthly benefit level calculated? A Regular Beneficiary'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 month of Active Service in the Plan. Each monthly contribution of \$50 is equal to one Active Service Unit. >The Unit Multiplier is a factor determined by the Trustees, with actuarial advice.

After retirement, the Trust Office will calculate your monthly benefit level by the following methodology (as further described in Plan Section 3.3, and illustrated in Appendix A of the Plan):

- Determine the total number of Active Service Units
- Multiply the 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 1.24, with the assistance of professional actuarial advice. You may contact the Trust Office to find out the current Unit Multiplier.

7. What is my monthly benefit level? A Regular Beneficiary's monthly benefit level is calculated by the methodology described above. As such, each Regular Beneficiary's monthly benefit level will be affected by the number of Active Service Units earned by the Employee over his or her career. This is determined by the monthly contribution rate negotiated by the Employee's bargaining unit. For example, a monthly contribution rate of \$150 will provide to each employee in that bargaining unit three Active Service Units per month, whereas a monthly contribution rate of \$200 will earn four Active Service Units per month. Thus, Regular Beneficiaries from different bargaining groups will have different monthly benefit levels, depending upon what contribution rate their bargaining groups selected and negotiated.

Adjustments to benefit level. The Trustees reserve the right and power to adjust the benefit levels up or down. Such adjustments, or termination of benefits, may apply to 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 Benefit Amount will be adjusted (up or down).

8. What will the benefit level be for my spouse and children in the event of my death?
Monthly Benefit Level. The monthly benefit level for a Surviving Spouse with Dependents is equal to 100% of the benefit level of the deceased Eligible Retiree. However, the monthly benefit level for a Surviving Spouse without Dependents is equal to 50% of the benefit level of the deceased Eligible Retiree. If there is no Surviving Spouse or Domestic Partner, the monthly benefit level for Surviving Dependents will be 50% of the benefit level for the deceased Eligible Retiree (to be divided equally among Dependents).

Employee Account. The Surviving Spouse, Domestic Partner, Dependent may be reimbursed for Covered Expenses limited to the balance of the decedent's Employee Account. Benefits cease when the account balance reaches zero.

9. 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 federal tax law. Federal tax law provides that 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. See Plan Section 3.3.

The Internal Revenue Service 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. The Plan Administrator will request information concerning registered Domestic Partnerships.

10. 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, the employee or surviving spouse or dependent must submit a written claim to the Board of Trustees at: Delta Health Systems, 555 W. Benjamin Holt Drive, Suite 320, Stockton, CA 95207 within thirty (30) days after the end of the Plan year in which the expense was incurred. Details for claim submission and appeal of claim denial are set forth in Article III, section 3.4, and Article IV of the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

11. What is the Plan Year?

The Plan year runs from October 1 to September 30.

12. What should I do if I change my address, spouse, or dependents? It is the Participant's responsibility to notify the Trust Office of any change in mailing address, spouse or dependents. Note that it is important to keep this type of information updated with the Trust Office so that notices related to the Plan and benefit payments may be sent to you and/or your Beneficiaries. Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan. Please update the Trust Office with any changes to your address or Beneficiaries by contacting the following: PORAC Retiree Medical Trust c/o Delta Health Systems Attn: Ms. Cindi Forbes 555 W. Benjamin Holt Dr., Ste. 320 Stockton, CA 95207 Phone: (800) 700-6762 Fax: (209) 955-4190

13. 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 after 24 months of benefits have been paid after the Eligible Retiree's death; and resume in the month the Spouse attains the eligibility age for the Employee under the Plan until the Spouse's death.
- A Surviving Dependent's benefits under this Plan will terminate upon the loss of dependent status.

Benefit coverage and benefit amounts may be modified or terminated pursuant to Article VI of the Plan and such changes may apply to current and/or future Beneficiaries. In the event of the termination of the Plan, assets of the Plan which 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.

14. What are the names and addresses of the Trustees? Earl Titman
Region I Novato Police Management Association

P.O. Box 2727
Novato, CA 94948

Bill Harbottle Region II Tulare County Deputy Sheriffs
Association 1616 W. Mineral King Suite C Visalia, CA 93291

John Snowling Region III Ventura Police Officers Association

P.O. Box 5130
Ventura, CA 93005

Rusty Rea Region IV Chula Vista Police Officers Association 49 3rd
Avenue Chula Vista, CA 91910

Russell Reinhart PORAC Board Representative Huntington Beach Police Officers
Association
P.O. Box 896 Huntington
Beach, CA 92648

15. Is there any other information about this I should know?

A. The name of the plan and trust.

This Plan is known as the “Medical Expense Reimbursement Plan of the PORAC Retiree Medical Trust,” effective September 1, 2008 and as amended from time to time hereafter (the “Plan,” *11/14/08 Edition*). The Plan is governed by the “Trust Agreement Governing the PORAC Retiree Medical Trust,” effective June 1, 2008 and as amended from time to time thereafter (“Trust Agreement”). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

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

The Plan was established by the Peace Officers Research Association of California (“PORAC”), which is a professional federation of local, state, and federal law enforcement associations for located within the state of California. The name, address and telephone number of the Association is as follows:

Peace Officers Research Association of California
4010 Truxel Road Sacramento, CA 95834 Phone:
(916) 928-3777

(800) 937-6722

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 80-6049077.

The Plan number is 501.

D. The type of plan.

The Plan is a welfare benefit plan providing health insurance premium and medical expense reimbursement benefits 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 permissible reimbursement under the Plan.

E. The type of administration/trust office.

The Plan is administered by the Board of Trustees of the PORAC Retiree Medical Trust. The Board has retained the services of a contract administrator to assist in recordkeeping, claims payments, etc. The contact information of the Trust Office is:

PORAC Retiree Medical Trust c/o Delta Health Systems
Attn: Ms. Cindi Forbes 555 W. Benjamin Holt Dr., Ste. 320
Stockton, CA 95207 Phone: (800) 700-6762 Fax: (209)
955-4190

F. The identity of the Plan Administrator.

The Plan Administrator (fiduciary) is the Board of Trustees of the PORAC Retiree Medical Trust. They may also be contacted in care of the Trust.

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

The Plan is maintained pursuant to various collectively bargained Memoranda of Understanding (“MOUs”), and applicable successor agreements, between the participating associations 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 MOUs upon written request to the Trust Office. Further, the MOUs 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 MOUs. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

H. Information regarding the Family Medical Leave Act.

If a covered Employee ceases active employment due to an Employer-approved family or medical leave of absence in accordance with the requirements of the Family and Medical Leave Act (Public Law 103-3), or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during the leave, coverage will be continued under the same terms and conditions which would have applied had the Employee continued in active employment, provided the Employee continues to pay his contribution share toward the cost of coverage, if any contribution is required. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

An FMLA leave will be deemed to terminate on the earlier of the following dates:

- The date the Employee uses up his FMLA leave entitlement. The date the
- Employee informs the Employer of his intent not to return from leave.

Please contact the Trust Office if you go on FMLA leave and would like to take advantage of your right to self-pay contributions under FMLA. 10

I. Information regarding Veterans' Rights.

If you are a returning veteran, please check with your employer regarding your rights.

J. Information regarding COBRA.

The General COBRA Notice is provided as a separate notice from this Summary Plan Description. If you have not received or would like to request a 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, and are made by the participating employers, based on the Memorandum of Understanding(s) with the participating Association(s), and by employees. Further, under certain circumstances, Beneficiaries may make self-payment contributions.

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

Contributions are received by and held in trust by the Trust and are invested with the assistance of a professional investment manager, utilizing 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 PORAC Retiree Medical 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 dependents may have to continue such contributions by self-payment. Review the General COBRA Notice and the Plan, Sections 2.2(d) and 2.2(e), 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 members to prevent them from obtaining a welfare benefit or exercising their rights under ERISA.

- Enforce Your Rights. If a claim for a welfare benefit is denied or ignored, in whole or in part, Beneficiaries 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).
- 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.

Internal Revenue Service Circular 230 Disclosure: As provided for in Treasury regulations, advice (if any) relating to federal taxes that is contained in this communication (including attachments) is not intended or written to be used, and cannot be used, for the purpose of (1) avoiding penalties under the Internal Revenue Code or (2) promoting, marketing or recommending to another party any plan or arrangement addressed herein.

**MEDICAL EXPENSE REIMBURSEMENT PLAN
OF THE
PORAC RETIREE MEDICAL TRUST**

PREAMBLE

WHEREAS, the Peace Officers Research Association of California (hereafter, PORAC) has decided to establish a retiree medical trust, to receive non-elective contributions from participating employers and employees, for the purpose of funding, in whole or in part, reimbursement of retiree health coverage;

WHEREAS, the PORAC established such a Trust as of June 1, 2008, granting administration of the Trust to a Board of Trustees pursuant to the "Trust Agreement Governing the PORAC Retiree Benefit Trust," effective June 1, 2008;

WHEREAS participating associations of PORAC may join the retiree medical trust, pursuant to Memoranda of Understanding (MOU) that require mandatory contributions, and other rules set by the Trustees

NOW THEREFORE, the Board of Trustees does hereby adopt this "Medical Expense Reimbursement Plan" of the PORAC Retiree Medical Trust, effective September 1, 2008, as set forth herein.

**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 "Active Service" means service as defined in Section 2.2 herein, after the Employee's Effective Date, provided however that an Employee may receive Active Service Units from contributions made to another similar Trust, if provided in a joinder agreement signed by this Trust. An **"Active Service Unit"** means a monthly Contribution of \$50 to the Trust on behalf of an Employee. Note that an Employee may earn more than one Active Service Unit in a month.

1.2 "Association" means a lawful labor organization that is a member Association in PORAC and represents Employees, and is party to a Memorandum of Understanding with a participating employer; or any rational class of individuals employed by a participating employer that is the subject of a special agreement as defined in the Trust Agreement, provided that such labor organization or class of employees has been accepted for participation by the Board of Trustees.

1.3 “Beneficiary” means an Eligible Retiree, his or her Surviving Spouse, and the Retiree’s Surviving Dependents. 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).

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

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

1.6 “Contribution” means a mandatory contribution for each and every employee in the bargaining unit represented by an Association, and made at the level of \$100 up to \$400, in increments of \$50 there between. 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 Sec. 4980B). Any elective contributions (other than under 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..

1.7 “Covered Expense” means payment for the following:

(a) premium or contribution payment on behalf of a Beneficiary to a health, dental, or vision insurance plan, for coverage 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 expense excludable from gross income under Code Section 213(d), i.e., costs for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury, incurred 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 Section 7702, for coverage 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.

1.8 “Dependent” means a “legal dependent” as defined by Code Section 152, and limited to children, stepchildren and adopted children thereunder.

1.9 “Domestic Partner” means a person who has met the criteria used to establish whether a person is a domestic partner under the California Family Code Section 297.

1.10 “Effective Date” for an Employee means the date that contributions for that Employee’s Association are required and made to the Trust, as approved by the Trustees.

1.11 “Eligible Retiree” means an Employee who is entitled to benefits under Section 2.1 of the Plan.

1.12 “Employee” means any individual employed as a permanent employee on or after that Employee’s effective date, who is a member of an Association that represents public safety employees; and on whom the required contributions are made to the Trust Fund pursuant to a Memorandum of Understanding or Special Agreement, as defined in the Trust Agreement, for all periods of Active Service after the Effective Date.

1.13 “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.

1.14 “Employer” or “Participating Employer” means an employer that contributes to this Plan pursuant to an MOU.

1.15 “ERISA” means the federal Employee Retirement Income Security Act, 29, USC 1001 et seq.

1.16 “Memorandum of Understanding” or “MOU” means a written agreement between an Employer and an Association that requires mandatory Contributions to a retiree medical trust on behalf of each Employee in the bargaining unit covered by the MOU, and subsequent amendments or successor agreements. The term MOU shall also include a Special Agreement that requires mandatory Contributions on each employee in an objective employment classification of an Employer during the period that the employer is also making contributions to the trust on the employees in the bargaining unit of the same Employer. If there are two MOUs from one employer (or an MOU and a Special Agreement), the contribution rate must be the one set in the MOU that covers non-management employees.

1.17 “Modify” means to adjust, including increase or decrease.

1.18 “Permanent” means either a part-time, or full-time employee filling a regular, permanent, exempt or nonexempt budgeted position, as defined in the applicable MOU.

1.19 “Plan” means this separate written document, together with any amendments duly adopted by the Trustees.

1.20 “Special 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. The Contribution under the Special Agreement must be at the same level as that in the MOU of the same employer.

1.21 “Surviving Spouse” means the lawful spouse, as defined in the Internal Revenue Code, who was in that status at least 12 months on the date of the Eligible Retiree’s death. The Surviving Spouse 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. To the extent allowed by federal law without jeopardizing the tax advantages of this Plan, the

Plan will also cover a Domestic Partner, as set forth in this Plan and recognizing that this may impose taxation on the employee who has a domestic partner.

1.22 “Trust” or “Trust Fund” means the PORAC 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 Delta Health Systems, 555 W. Benjamin Holt Drive, Suite 320, Stockton, California 95207.

1.23 “Trust Agreement” or “Agreement” means the Trust Agreement governing the PORAC Retiree Medical Trust, effective June 1, 2008, and any amendments thereto.

1.24 “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 3.3(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 an Eligible Retiree entitled to monthly benefits as a Regular Beneficiary under Section 3.2 hereof when he or she meets all the following requirements in this Section 2.1(a).

(1) The Employee earns ten years of Active Service; provided however, that for a person who is an Employee on the date that contributions to this Trust, or a prior similar trust, began for his or her Association, this requirement shall be five years.

(2) Ten years have passed since the commencement of contributions (or five years if the five year rule applies in subsection 2.1(a)(1) hereof).

(3) Contributions are made to the Trust on the Employee for all years of Active Service.

(4) The Employee attains age 55 if a sworn public safety employee, and 58 for other employees.

(5) The Employee has ceased employment as an Employee under this Plan.

(b) Eligibility as a Limited Beneficiary: Employee Account Benefits. An Employee who does not meet the requirement for years of Active Service under Section 2.1(a) of this section shall become an Eligible Retiree as a Limited Beneficiary under this Plan,

entitled to receive benefits from his or her Employee Account, if there have been deposits thereto, pursuant to Section 3.5 of the Plan. (A Regular Beneficiary may also have an Employee Account for mandatory transfer of accumulated leave, etc.)

2.2 Active Service.

(a) Bargaining Unit Service. Active Service is used to determine an Employee's eligibility under this Plan. An Employee may earn Active Service in the following ways:

- (1) For employment as a permanent Employee of any participating employer;
- (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 Plan during that time; and
- (3) For service in the Armed Forces, as required by federal law.

(b) Non-Bargaining Unit Service. An Employee who has earned Active Service under subsection 2.2(a) hereof and who has transferred out of a participating Association (e.g., through promotion or other action) may continue to earn Active Service only if covered by an MOU (as defined herein) in the new position.

(c) Retirement that Occurs Within 42 Months After Commencement of Participation. An Employee who ceases to earn Active Service under the Plan due to retirement from his or her participating employer within forty-two months of commencement of contributions to the Plan, and who is covered by an MOU that provides for mandatory transfer of accumulated leave, is entitled to earn Active Service in order to become an Eligible Retiree, by mandatory transfer of accumulated (e.g., sick) leave into the Plan, but only if the following rules and procedures are satisfied. Alternatively, the Employee may elect to have the transfer credited to his Employee Account in the Trust; and such transfer is subject to subsections 2.2(c)(1), (5) and (6) hereof.

- (1) The transfer is pursuant to a non-elective requirement for such transfer in his or her MOU.
- (2) The Plan converts that portion of the leave transfer necessary to satisfy Section 2.1(a)(1) into years (or partial years) of Active Service according to a formula set by the Trustees.
- (3) The conversion to Active Service is limited to the amount necessary for the Employee to satisfy the requirement in Section 2.1(a)(1); the balance of the leave accumulation is credited to his or her Employee Account.
- (4) The first eighteen months of conversion is considered the Employee's payment pursuant to sub-section 2.2(d) hereof, in order that the Employee can make the eighteen months of COBRA payments on a pre-tax basis.
- (5) The transfer of sick leave occurs by a lump sum at one time, within ninety days of retirement (not monthly).

(6) The Employee's benefits payments as a Regular Beneficiary do not commence until the period of time set forth in Section 2.1(a)(2) has passed.

(d) Contribution after Termination or Reduction of Employment (COBRA). An Employee whose employment is terminated 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. An Employee whose employment is reduced may continue to self-pay so long as he is employed by a participating employer.

(e) Spouse or Dependent Contribution after Death of Employee (COBRA). After death of an Employee, a Surviving Spouse or Dependent may continue to earn Active Service by periodic self-payment of contributions, for a maximum of thirty-six months, pursuant to rules set by the Trustees.

(f) Self-Pay Rules. Self payment rules for purposes of Sections 2.2(d)-(e) shall be set by the Trustees and may be obtained from the Trust Office.

2.3 No Rebate or Refund. Employees shall not be eligible for rebates or refunds of any contributions made, except as benefits as set forth in the Plan. Provided however, that any elective contributions (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 an elective contribution will be rescinded.

ARTICLE III BENEFITS

3.1 General.

(a) An Employee may become a Beneficiary either under Section 2.1(a) or 2.1(b), or both. The rules in Sections 3.3 and 3.4 apply to payments to Regular Beneficiaries, i.e., those Retirees who become eligible under Section 2.1(a). The rules in Section 3.5 apply to payments to Limited Beneficiaries, i.e., those Retirees 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 Section 3.6 hereof.

(b) 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.

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

(a) Retiree. A Regular Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(a) and having contributions made to

(3) Employer contributions, on the condition that the Employee terminates from the employer at the retirement age as defined in the retirement system of his or her employer.

(4) Earnings, minus a proportionate share of expenses.

(b) Benefit Level from Employee Account. There shall be no maximum amount on a claim against the Employee Account, so long as all claims are for reimbursement of Covered Expenses, i.e., the monthly Unit Multiplier calculation does not apply to Employee Accounts.

(c) Commencement and Termination of Benefits from Employee Account. Reimbursement from the Employee Account may commence after and during separation from service with a participating employer, and will terminate when the Account balance reaches zero. If the Eligible Retiree returns to employment with a participating employer, eligibility for this benefit shall be suspended until termination of such employment.

(d) Forfeitures. Any balance left in the Employee Account upon the death of the Beneficiary and his or her surviving Beneficiaries will forfeit to the Plan.

(e) Modification of Rules. The Trustees may modify or amend the rules for benefit payments from Employee Accounts, which may apply to current and/or future Beneficiaries.

3.4 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:

Delta Health Systems 555 W. Benjamin
Holt Drive, Suite 320 Stockton,
California 95207-3839 Fax: (209)
955-4190

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) 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.

(d) In order to be paid, a claim for Plan benefits must be submitted within 30 days after end of the Plan year in which the expense was incurred.

(e) Subject to subsection (f), 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.

(f) 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.

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 3.6 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) 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 3.6(b). 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.

(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 of 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.

The denial notification shall include the following information:

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) Sole Procedures. The procedures specified in this Section shall be the sole and exclusive procedures available to a person dissatisfied with an eligibility determination or benefit award, or 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 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 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' receipt of request for review. If such an extension of time 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) Reference to the specific Plan provisions, or internal rule, guideline, protocol or similar criterion, upon which the denial is based, and a statement that a copy will be provided free of charge to the claimant upon request;
- (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; and
- (4) A statement that the Beneficiary may have other voluntary alternative dispute resolution options, such as mediation; and that one way to find out what may be available is to contact your local U.S. Department of Labor Office.

(e) Right to Federal Court Review, etc. Upon exhaustion of these procedures in this Article IV, the Beneficiary who is dissatisfied with an eligibility determination or benefit award or who is otherwise adversely affected by any action of the Trustees, may then bring an action in federal court pursuant to ERISA Section 502(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 Association, 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 Association, 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 any Association, 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 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 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, but upon a non-discriminatory basis:

- (a) To modify the Unit Multiplier.
- (b) To amend or rescind any provision of this Plan.

(c) To terminate the Plan.

Any such changes may apply to current and/or future 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 by the Board of Trustees this 16th day of September 2008; and effective November 1, 2008.

**For the BOARD OF TRUSTEES,
PORAC RETIREE MEDICAL TRUST**

Earl Titman, Chairperson, Region I Bill
Harbottle, Secretary, Region II John Snowling,
Region III Rusty Rea, Region IV Russell Reinhart,
PORAC Board Representative

**APPENDIX A Examples of Calculation of
Benefit Level**

\$50 monthly contribution = 1 Active Service Unit
Unit Multiplier for all eligible Beneficiaries = \$0.40*

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

Step 1: Convert monthly contributions to Active Service Units
\$100/month = 2 Active Service Units/ Month \$150/month = 3
Active Service Units/ Month

Step 2: Find number Active Service Units 2 Active Service Units x 24 months =
48 Active Service Units 3 Active Service Units x 48 months = 144 Active
Service Units
Total = 192 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier:
Monthly Benefit Amount: 192 x \$0.40 = \$76.80

* * *

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

Step 1: Convert monthly contribution to Active Service Units.
\$100/month = 2 Active Service Units/ Month \$200/month = 4
Active Service Units/ Month

Step 2: Find number Active Service Units. 2 Active Service Units x 84 months =
168 Active Service Units 4 Active Service Units x 60 months = 240 Active
Service Units
Total = 408 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 408 x \$0.40 = \$163.20

**The Unit Multiplier (UM) used in this Appendix B is an example and only for illustration purposes. The Trustees have not yet adopted a UM, but will 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.*

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

Step 1: Convert monthly contributions to Active Service Units.
\$100/month = 2 Active Service Units/ Month \$200/month = 4
Active Service Units/ Month

Step 2: Find number Active Service Units.
2 Active Service Units x 84 months = 168 Active Service Units
4 Active Service Units x 216 months = 864 Active Service Units
Total = 1032 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Amount: 1032 x \$0.40 = \$412.80

* * *

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: Delta Health Systems at (800) 700-6762 .