

AMENDED
PREMIUM REIMBURSEMENT PLAN

OF THE

VENTURA COUNTY PROFESSIONAL
FIREFIGHTERS' ASSOCIATION
BENEFIT TRUST

AND

SUMMARY PLAN DESCRIPTION

Effective February 16, 2017

**PREMIUM REIMBURSEMENT PLAN
OF THE
VENTURA COUNTY PROFESSIONAL FIREFIGHTERS' ASSOCIATION
BENEFIT TRUST**

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**PREMIUM REIMBURSEMENT PLAN
OF THE
VENTURA COUNTY PROFESSIONAL FIREFIGHTERS' ASSOCIATION
BENEFIT TRUST**

PREAMBLE

WHEREAS, the Ventura County Fire Protection District (the "District") and the Ventura County Professional Firefighters' Association ("VCPFA") entered into a Memorandum of Agreement ("MOA") in August, 1995; and

WHEREAS, the District and the VCPFA executed an Amendment to the MOA on January 2, 1996, wherein the District agreed to make contributions to a benefit trust established by the VCPFA for the purpose of funding a retiree medical premium reimbursement plan; and

WHEREAS, the VCPFA established such a Trust as of July 1, 1996, granting administration of the Trust to a Board of Trustees pursuant to the Trust Agreement governing the VCPFA Benefit Trust, effective July 1, 1996;

WHEREAS, the Board of Trustees previously adopted the Premium Reimbursement Plan, effective July 17, 2007, as set forth (as amended) in the following pages (including Plan Amendments 1-8);

NOW, THEREFORE, the Board of Trustees do hereby adopt this Amended Premium Reimbursement Plan, effective February 16, 2017, as set forth (as amended) in the following pages by incorporating Plan Amendments 1-9.

**ARTICLE I
DEFINITIONS**

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

- 1.1 "Active Service"** means service as defined in Article 2 herein.
- 1.2 "Association" or "VCPFA"** means the Ventura County Professional Firefighters' Association of Ventura County.
- 1.3 "Beneficiary"** means an Eligible Retiree and his or her Surviving Spouse and Dependents.
- 1.4 "Benefit Amount"** means the amount set from time to time by the Trustees as the monthly maximum amount available for payment of Premiums.

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

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

1.7 “Dependent” means the unmarried natural child or lawfully adopted child of the Employee or Eligible Retiree, or child placed in the Employee’s or Retiree’s home for adoption, who, at the time of an Employee’s or Retiree’s death, meets one of the following requirements:

- (a) Is a legal dependent under the age of 18;
- (b) Is a legal dependent under the age of 23 and is a full-time student; or
- (c) Is a child of any age who is legally dependent upon the Employee or Retiree for support and maintenance and is unable to care for himself by reason of mental retardation or physical handicap.

1.8 “District” means the Ventura County Fire Protection District.

1.9 “Effective Date” means July 1, 1996.

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

1.11 “Employee” means an individual employed by the District on or after the Effective Date who is a member of the bargaining unit represented by the VCPFA, or who has promoted out of that bargaining unit, and on whom the required contributions are made to the Fund for all periods of Active Service after the Effective Date.

1.12 “Medicare Eligibility Age” means the age under the federal Social Security Act at which an individual is eligible, based on age, to apply for Medicare health insurance benefits.

1.13 “Memorandum of Agreement” or “MOA” means the written agreement between VCPFA and the District entered in August, 1995, and subsequent amendments or successor agreements.

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

1.15 “Premium” means a premium or contribution payment for a Beneficiary to a health plan or long term disability plan that provides coverage for the type of medical expenses excludible under Internal Revenue Code 105 (b), for coverage in effect while the Beneficiary is eligible for benefits under this Plan.

1.16 “Surviving Spouse” or “Spouse” means the lawful spouse of an Eligible Retiree to whom the Eligible Retiree was married for at least 12 months on the date of the Eligible Retiree’s death.

The spouse of an Employee who has satisfied all the requirements of Section 2.1 except the Employee dies before attaining age 55 shall also be considered a Surviving Spouse.

1.17 “Trust” or “Trust Fund” means the VCPFA Benefit Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records.

1.18 “Trust Agreement” or “Agreement” means the Trust Agreement governing the VCPFA Benefit Trust, effective July 1, 1996, and any amendments hereto.

ARTICLE II ENTITLEMENT TO BENEFITS

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

- (a) The Employee ceases employment with the District and is eligible to receive retirement benefits from the District;
- (b) The Employee has earned ten years of Active Service, at least five of which are earned as a VCPFA bargaining unit Employee;
- (c) Contributions have been made to the Plan on behalf of the Employee for all periods of Active Service after the Effective Date (subject to Article 2.1(e)); and
- (d) The Employee attains age 55.
- (e) A minimum of five years’ worth of contributions is required to become an Eligible Retiree.
 - (1) Required self-payments for retirements prior to July 21, 2001. An Employee who retires prior to July 21, 2001, shall be required to make a lump sum contribution to the Trust, within thirty (30) days of his or her retirement, in an amount equal to the difference between what the District would have paid on behalf of the Employee over the period of July 1, 1996, to July 1, 2001, pursuant to the MOA, and the amount the District already paid on behalf of the Employee at the time of his or her retirement.
 - (2) Forfeiture if no payment. Failure to make the required contribution, as described in subparagraph (1) hereof and determined by the Trustees, on a timely basis, will result in permanent forfeiture of all Active Service in, and benefits from, the Plan, including Active Service and benefits earned prior to retirement.

2.2 Active Service.

- (a) Bargaining Unit Service. Active Service is used to determine an Employee's eligibility under this Plan. Any partial years of full-time Active Service shall be counted to the nearest fractional one-twelfth of a year. An Employee may earn Active Service in the following ways:
- (1) For full-time employment as an Employee;
 - (2) For time as an Employee on authorized leave of absence from the District due to service related disability, illness, or injury; and
 - (3) For service in the Armed Forces, as required by federal law.
- (b) Management Service.
- (1) Required self-payment. An Employee who promotes to a District position not included in the bargaining unit covered by the VCPFA Memorandum of Agreement shall continue to participate in the Plan during such employment, provided that the Employee pays the required contribution for all such periods of non-bargaining unit employment.
 - (2) Rate. The Employee shall be responsible to make or arrange for payment to the Trust of such contributions on a monthly basis, by the first of every month for that month, until termination of employment with the District, at the rate of 2.0% of the highest monthly base salary in the VCPFA bargaining unit at the time of the contribution.
 - (3) Forfeiture if no payment. Failure to make the required contributions on a timely basis will result in permanent forfeiture of all Active Service in, and benefits from, the Plan, including Active Service and benefits earned prior to promotion out of the bargaining unit.
- (c) Service Prior to the Effective Date. An Employee shall receive Active Service for 50% of all years of full-time employment as an Employee preceding the Effective Date, during which the Employee was a paid member of VCPFA.
- (d) Contribution after Termination or Reduction of Employment. An Employee whose employment is terminated or reduced to less than full-time (except for gross misconduct), may continue to earn Active Service for a maximum of eighteen months, by periodic self-payment of contributions, pursuant to rules set by the Trustees. Self-payment rules for this purpose may be obtained from the Trust office.

- (e) Spouse or Dependent Contribution After Divorce, Death of Employee. A Spouse or Dependent of an Employee may also be entitled to self-pay contributions after divorce from or death of an Employee, to earn Active Service, for a maximum of thirty-six months, pursuant to rules set by the Trustees. Self-payment rules for this purpose 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.

ARTICLE III BENEFITS

- 3.1 **General.** Subject to the exclusions and limitations set forth in this Plan, a Beneficiary is entitled to the reimbursement of Premiums paid on or after July 1, 2001, by the Beneficiary, subject to proper and timely submission of documentation substantiating payment made by the Beneficiary, in an amount not to exceed the Benefit Amount. Eligibility to receive reimbursement of *Premiums* will start on the first day of the month following the month in which a Beneficiary's eligibility for benefits and effective date of coverage are determined. In no event will a Beneficiary be eligible for reimbursement of any Premium paid for any month of coverage that commenced prior to the Beneficiary's effective date of coverage under the Plan.

3.2 **Benefit Amount.**

3.2.1 Basic Benefit.

- (a) **General.** Effective July 1, 2001, the Basic Benefit Amount is a maximum of Two Hundred Fifty Dollars (\$250.00) per month, not to exceed the actual Premiums paid by the Beneficiary. The Trustees may adjust the Basic Benefit Amount from time to time.
- (b) **Adjustments.** Although the Trustees hope to provide benefits for the indefinite future, the Trustees nonetheless reserve the right and power to adjust the benefit levels up or down, and to terminate the Plan at any time in its sole discretion. Such adjustments or termination could apply to current as well as future retirees. In case of termination, plan assets will be distributed to plan participants according to IRS rules.

3.2.2 Supplemental Benefit.

- (a) **General.** Effective July 1, 2017, the *Trustees* at their discretion may authorize a monthly supplemental benefit to *Eligible Retiree's* that ~~are~~ have not yet attained the *Medicare Eligibility Age*. The Supplemental Benefit is in addition to the basic benefit provided in Section 3.2.1. The combined Basic Benefit and Supplemental Benefit shall not exceed the actual *Premiums* paid by the *Eligible Retiree*. *Surviving Spouses* and *Dependents* are not eligible for the Supplemental Benefit.
- (b) **Supplemental Benefit Amount.** The monthly Supplemental Benefit amount shall be determined in accordance with the following:

- (1) The amount of the monthly Supplemental Benefit, if any, shall be determined by the *Trustees* by June 1 for the following fiscal year benefit.
 - (2) The *Trustees* shall consider the following when establishing the Supplemental Benefit:
 - (i) The previous 5-year average investment return
 - (ii) Projected future investment returns
 - (iii) Continued growth of the *Trust Fund* to provide for Basic and Supplemental Benefits to *Employees* when they become *Eligible Retirees*.
 - (3) Like all other benefits under the Plan, the Supplemental Benefit is not a guaranteed benefit and may be adjusted each year up or down including no Supplemental Benefit for the year.
- (c) **Termination of Supplemental Benefit.** The Supplemental Benefit shall terminate on the first day of the month that an *Eligible Retiree* attains the *Medicare Eligibility Age*.

3.3 Survivors' Benefits. Upon the death of an Eligible Retiree prior to retirement, or of a Retiree while receiving benefits from the Plan, the Plan provides the following Survivors' Benefits:

- (a) **Surviving Spouse.** Upon attaining age 55, the Surviving Spouse shall receive 50% of the amount set forth in Article 3.2 until the Spouse's death or remarriage.
- (b) **Surviving Dependents Only.** If there are only Dependents, or the Surviving Spouse has not attained age 55, the Surviving Dependents shall be entitled to share equally in the amount set forth in subsection 3.2 until the earliest of the time the Spouse reaches age 55, or each Dependent loses Dependent status; provided that when there is only one Dependent, the benefit shall be 50% of the amount set forth in subsection 3.2.

3.4 Termination of Benefits.

- (a) **Eligible Retirees.** An Eligible Retiree's benefit coverage under the Plan shall terminate on the first to occur of the following:
 - (1) The date the Retiree again becomes employed as a firefighter for any employer within the state of California; or
 - (2) The date of the Retiree's death, although claims for Premiums incurred prior to death, which are properly and timely submitted, will be paid.
- (b) **Surviving Spouse.** A Surviving Spouse's benefit coverage under the Plan shall terminate on the first to occur of the following:
 - (1) The remarriage of the Surviving Spouse; or

- (2) The date of the Surviving Spouse's death, although claims for Premiums incurred prior to death, which are properly and timely submitted, will be paid.
- (c) Benefit coverage may be modified or terminated pursuant to Article VI hereof.

3.5 Benefit Claim Procedure.

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

VCPFA Benefit Trust
c/o Ventura County Professional Firefighters Association
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012

Claims will be paid twice a year upon presenting proof of payment of Premiums.

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 under Section 4.3 hereof.
- (c) Proof 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) Claims for Plan benefits must be submitted no later than 180 days from the date on which the Beneficiary made the payment of Premiums to the insurance provider.
- (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 3.5 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 3.5(b) of this Article IV. 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:

- (i) The specific reason(s) for such denial;
 - (ii) Specific reference to the Plan provisions upon which the denial is based;
 - (iii) 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
 - (iv) 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 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 thirty (30) 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 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 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 forty-five (45) 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) 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 (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. No later than sixty (60) days after receipt by the Plan of the claimant's request for review of an adverse benefit determination, the Trustees shall issue a written decision, affirming, modifying or setting aside the former decision. Provided however, that if the claimant waives the sixty (60) day deadline, for the claimant's convenience in setting a hearing, then the Trustees shall have no more than thirty (30) days after the date of the hearing to issue the decision. Any notification of a denial of benefits shall include the following information:
 - (i) The specific reason(s) for such denial;
 - (ii) Specific reference to the Plan provisions upon which the denial is based;
 - (iii) 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
 - (iv) An explanation of the Beneficiary's right to bring an action in federal court under ERISA Section 502(a).

- (d) Right to Federal Court Review. 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 the Association or its employees, the Benefit Trust or its employees, or the Trustees, except as provided in this Plan and the Trust Agreement.
- 5.2 Applicable Laws and Regulations.** Reference in this Plan to any particular sections of any local, state or federal statute shall include any regulation pertinent to such sections and any subsequent amendments to such sections or regulations. Except where this Plan is subject to California law, this Plan and the Fund shall be guided by ERISA.
- 5.3 Confidentiality.** It is agreed and understood that each Beneficiary or Employee 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 VCPFA, its officers, agents or employees, any matters revealed to them in confidence by such Beneficiary in the course of his or her application for benefits, except to the extent required by law.
- 5.4 Trustee Authority.** The Trustees shall have the authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of this Trust and Plan, or of the benefit plans, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision shall be binding and conclusive.

ARTICLE VI AMENDMENTS AND TERMINATION

In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Beneficiaries, the Trustees expressly reserve the right, in their sole discretion, at any time and from time to time, but upon a non-discriminatory basis:

- (a) To adjust the Benefit Amount, (for current and or future retirees).
- (b) To amend or rescind any provision of this Plan.
- (c) To terminate the Plan.

Amendments shall be made by action of the Board of Trustees pursuant to Article IX of the Trust Agreement.

**ADOPTED: BOARD OF TRUSTEES
VENTURA COUNTY PROFESSIONAL FIREFIGHTERS' ASSOCIATION
BENEFIT TRUST on February 16, 2017**

Wayne Maynard, Chair

Ed Gavirati, Trustee

Gary Oliver, Trustee

Gary Desgagnes, Trustee

Jon Bergh, Trustee

SUMMARY PLAN DESCRIPTION

a. Name of Plan

This Plan is known as the Premium Reimbursement Plan of the Ventura County Professional Fire Fighters' Association Benefit Trust. The Plan is sponsored through the County of Ventura and the Ventura County Professional Fire Fighters' Association. (VCPFA)

b. Name, Address and Telephone Number of Plan Administrator

This Plan is administered by a board of trustees of the VCPFA Benefit Trust, the name, address and telephone number which is:

Board of Trustees of the Premium Reimbursement Plan of the VCPFA Benefit Trust
c/o the Ventura County Professional Fire Fighters' Association
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012
(805) 484-8844

Upon written request to the Board of Trustees, the beneficiaries of the Plan may obtain a complete list of the employers and employee organizations sponsoring the Plan and may receive information as to whether a particular employer or employee organization is a sponsor of the Plan.

c. Identification Numbers

The Employer Tax Identification Number assigned to the Plan by the Internal Revenue Service is EIN 31-1567720.

The Plan Number is 501.

d. Type of plan

This Plan can be described as a welfare benefit plan providing health insurance premium reimbursement benefits.

e. Type of administration

The Plan is administered by the Board of Trustees of the VCPFA Benefit Trust. The Board's address and telephone number are listed in Item b.

f. Name and address for 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 Plan trustee or the Plan administrator. The names and addresses of the Trustees are set forth below:

Wayne Maynard, Chairman
c/o VCPFA
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012

John Bergh, Treasurer
c/o VCPFA
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012

Gary Oliver, Secretary
c/o VCPFA
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012

Ed Gavirati, Vice-Chairman
c/o VCPFA
3251 Corte Malpaso, Suite 501 C
Camarillo, CA 93012

Gary Desgagnes, Trustee
c/o VCPFA
3251 Corte Malpaso, Suites 501 C
Camarillo, CA 93012

g. Description of Bargaining Agreement

This Plan is maintained pursuant to a collective bargaining agreement, which is the “Memorandum of Agreement between Ventura County and VCPFA” (MOA) effective June 30, 1998. Beneficiaries of the Plan (i.e., employees, eligible retirees and surviving spouses, as defined in the “Plan and Trust Document”) may obtain copies of this MOA, upon written request to the Plan Administrator. Further, the MOA is available for examination by Beneficiaries at the Plan Administrator’s office.

The Trustees may impose a reasonable charge to cover the cost of providing copies of the MOA. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

h. Participation, eligibility and benefits

1. Eligibility in the Plan is generally open to all employees who are members of the VCPFA or who have promoted out of that bargaining unit, or a bargaining unit represented by an association which has been approved by the Trustees to participate in the Plan and on whom the required contributions are made to the Trust. See Plan Sections 2.1 and 2.2 for details.
2. Such employees become entitled to benefits of this Plan, generally, upon earning ten years of Active Service, attainment of age fifty-five (55) and contributions have been made on behalf of the Employee for all periods of Active Service. See Plan Section 2.1- 3.2 for details.
3. Eligible Retirees are entitled to reimbursement of premiums paid for coverage in effect on or after July 1, 2001, as defined in Section 3.1 of this Plan. The amount of benefits is determined by the Trustees from time to time based on available Trust assets as set forth in Article III of the Plan. There are also survivor benefits for eligible surviving spouses and dependents as set forth in Plan Section 3.3.

i. Procedures Governing Qualified Medical Child Support Order Determinations (QMCSO)

Beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator (Noted in item b).

j. Description of Cost Sharing Provisions

This Plan only reimburses toward the cost of health insurance coverage premiums and long term disability insurance premiums. Plan beneficiaries will be responsible for the balance of any premiums not paid by the Plan's benefit.

k. Circumstances Which 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 to make required contributions, failure to properly submit expense receipts, failure to meet the eligibility requirements, death, employment as a firefighter within the state of California after retirement, or termination of the Plan. A surviving spouse's benefit coverage shall terminate on the first to occur of the following: 1) Remarriage of the surviving spouse; or 2) The date of the surviving spouse's death,

although claims for Premiums for coverage prior to death, which are properly and timely submitted will be paid. The Board of Trustees reserves the right to adjust the benefit amount, amend, modify or terminate the Plan at any time.

I. Distributions on Termination

In the event of the termination of the Plan, assets of the Plan which remain after expenses, associated with such termination, will be allocated among, and distributed to, the Beneficiaries at such time and in the form as determined by the Board of Trustees and pursuant to the Plan.

m. Continuation Coverage for Qualified Beneficiaries Pursuant to COBRA

1. **COBRA** If you are covered by this Plan you have the right to continue contribution to this Plan, in order to receive coverage after retirement in certain instances where coverage under this Plan would otherwise end. This continued participation is a right governed by federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as your “COBRA” right. This notice is intended to inform you of your rights and obligations under COBRA. You, and your spouse if married, should take the time to read this notice carefully.

2. **Qualifying Events** If you are an Employee, and you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), these are called “Qualifying Events,” which give you the right to continue contributions to the Plan.

If you are the spouse of an Employee covered by this Plan, you have the right to choose continued participation for yourself if you lose coverage under this Plan for any of the following four reasons, which also are “Qualifying Events”:

- (a) The death of your spouse,
- (b) A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment,
- (c) Divorce or legal separation from your spouse, or
- (d) Your spouse becomes eligible for Medicare.

Dependent children of an employee covered by this Plan may also have rights to continue contribution to this Plan if coverage under this Plan is lost for any of the following Qualifying Events:

- (a) The death of a parent,
- (b) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment,
- (c) Parent's divorce or legal separation,
- (d) A parent becomes entitled to Medicare, or
- (e) The dependent ceases to be a "dependent child" under the Plan.

A child who is born to or placed for adoption with an employee who is already receiving continuation coverage is also eligible for continued participation.

3. **Notice Requirements.** Under COBRA, the employee or a family member has the responsibility to inform the Trust of a divorce, legal separation, or a child losing dependent status under this Plan. This notice must be given in writing to the Trust Office within sixty (60) days after the Qualifying Event or within sixty (60) days after the date coverage would be lost, if later.

When the Trust is notified that one of these Qualifying Events has happened, it will in turn notify you that you have the right to choose to continue your contribution. You have at least sixty (60) days from the date you would lose coverage because of one of the Qualifying Events described above to inform the Trust that you want to continue participation.

If you do not choose to continue making contributions to this Plan, your coverage under this Plan will end.

4. **COBRA Coverage Means the Right to Continue Contributions to the Plan.** The type of continuation coverage in this type of plan is unusual. It means the employee's (or family member's) right to continue to self-pay the contributions that were being paid by the employer under the collective bargaining agreement¹. These contributions are intended to entitle you to health premium reimbursements after retirement.

In this Plan, the Trust must have received ten (10) years of contributions during an employee's active employment in order for the employee to receive

¹ In a typical health plan, the COBRA right entitles the employee to self-pay contributions to continue to receive current health coverage. In contrast, this Plan does not pay coverage to active employees, but instead accepts contributions during active employment, which are being held by the Trust to purchase health coverage after the employee retires.

premium reimbursement benefits after retirement. Therefore, depending on how many years of contributions have been made on an Employee at the time of the Qualifying Event, it may be advisable for the employee to continue to self-pay the contributions in order to become entitled to the retiree benefits.

Divorced or widowed spouses, and dependent children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office for details.

5. **Length of COBRA Coverage.** The COBRA law requires that you be afforded the opportunity to maintain continuation coverage for thirty-six (36) months (three years) unless you lost coverage because of a termination of employment or reduction in hours. In that case, the required self-payment period is eighteen (18) months. The eighteen (18)-month period may be extended to thirty-six (36) months if a second event (divorce, legal separation, death or Medicare entitlement, but not termination of employment) occurs during that eighteen (18)-month period. In addition, if employer contributions terminate due to the employee's termination of employment or reduction in hours which occurs less than eighteen (18) months after the date an employee becomes entitled to Medicare benefits, the self-payment period for a spouse or dependent child is extended to thirty-six (36) months from the date of the employee's Medicare entitlement.

The eighteen (18)-month period may be extended for an additional eleven (11) months (for a total of twenty-nine (29) months) if an individual becomes disabled (as determined under the rules for Social Security disability benefits) within the first sixty (60) days of continuation coverage and the Trust Office is notified of the Social Security determination within sixty (60) days of the determination and before the end of the eighteen (18)-month period. The affected individual also must notify the Trust Office within thirty (30) days of a determination (for purposes of Social Security disability benefits) that the individual is no longer disabled. The eleven (11)-month extension applies to all disabled and non-disabled individuals entitled to continuation coverage as a result of the same event. Please note the cost you pay for the additional eleven (11) months will be approximately 50% higher than the cost for the first eighteen (18) months if the continuation participation includes the disabled individual and the continued participation would not be available in the absence of a disability.

6. **Termination of COBRA Coverage.** The COBRA law provides that your continued participation may be cut short of the full coverage period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

- (a) The Trust no longer maintains a group health plan,

- (b) The premium for your continued participation is not timely paid,
- (c) You become enrolled in Medicare, or
- (d) There has been a final determination that you are no longer disabled if you qualified for an extra eleven (11) months continuation coverage based on disability.

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

If you have any questions about COBRA, you should contact the Trust Office at 3251 Corte Malpaso, Suite 501 C, Camarillo, CA 93012 or phone (805) 484-8844. Also, if you have changed marital status, or you or your spouse have changed address, please notify the Trust office.

n. Source of contributions

Contributions to this Plan are made by Ventura County, based on the Memorandum of Agreement between Ventura County and VCPFA. There are also, under certain circumstances, employee contributions.

o. Methods used for accumulation of assets

Contributions are received by and held in trust by the Trust and they may be invested with the assistance of a professional investor, utilizing investment policies and methods consistent with objectives of the Plan, and the Employee Retirement Income Security Act of 1974 (ERISA) requirements.

p. End of plan year

The Plan runs on a calendar year from July 1 to June 30.

q. Procedures to be followed in presenting claims for benefits and appeal procedures for denied claims

The Plan's Claim and Appeal Procedures will be furnished automatically, without charge, as a separate document. The Claim Procedures are also contained in Section 3.5 of the Plan and the Appeal procedures are contained in Article 4 of the Plan (in this booklet).

r. Statement of legal rights

1. **Rights of Plan Participants.** Beneficiaries of the VCPFA Benefit Trust are entitled to certain rights and protection under the Employee Retirement Income

Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- (a) Examine without charge at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the 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 Pension and Welfare Benefit Administration.
- (b) Obtain upon written request to the Plan administrator, copies of documents governing the operation of the 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
- (c) 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.
- (d) If there is a loss of coverage under the Plan as a result of a qualifying event you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- (e) If you have creditable coverage from another plan you should be provided a certificate of creditable coverage, free of charge, from your Group Health Plan or health insurance issuer in certain circumstances when you lose coverage under this Plan. (Currently, this subsection (e) is not applicable to this Plan.)

2. **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.

3. **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 \$200 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.

4. **Assistance with Your Questions.** If you have any questions about your 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.