February 2015

Plan Summary

HRA VEBA Plan

Health reimbursement arrangements for public employees in the Northwest

This Plan Summary explains how to use your HRA VEBA Plan benefits. It also describes the rights and responsibilities of those covered by the plan. You and all covered individuals should read and become familiar with its content.

Sign up for direct deposit and e-communication! Log in at **hraveba.org** and click **My Profile**.

Standard HRA Plan
Post-separation HRA Plan

hra veba

HRA VEBA Plan Customer Care Center
PO Box 80587, Seattle, WA 98108
Phone: 1-888-659-8828
Fax: (206) 577-3020
E-mail: customercare@hraveba.org

hraveba.org

HV04 (2/15 PRC)

Welcome!

Please carefully read this Plan Summary. It contains important information about how to utilize your HRA VEBA Plan participant account(s). It also describes your rights as a participant in one or more of the health reimbursement arrangement (HRA) plans offered by the HRA VEBA Trust. Please keep this Plan Summary in a safe place for future reference.

If you haven't already done so, sign up for direct deposit and e-communication. Log in at **hraveba.org** and click **My Profile**. After logging in, you can also do the following:

- View your account balance(s)
- View claims history (if you are claims-eligible)
- Submit a claim (if you are claims-eligible)
- Update your investment selection(s)
- Update your account information, including covered individuals, contact information, etc.

Contact the HRA VEBA Plan's customer care center at **customercare@hraveba.org** or **1-888-659-8828** when you have questions about your participant account(s), including available balance, claims, eligible expenses, spouse/dependent eligibility, etc.

In the event of a discrepancy between this Plan Summary and the actual Plan and Trust documents, the Plan and Trust documents control. **The Plan Summary supersedes any previously published Plan informational materials.**

Sincerely,

HRA VEBA Board of Trustees

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HRA VEBA Plan Customer Care Center
PO Box 80587, Seattle, WA 98108
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PART I QUESTIONS AND ANSWERS

What is the HRA VEBA Plan?

The HRA VEBA Plan is a funded health reimbursement arrangement (HRA). Your employer makes contributions to either Plan on your behalf. Your HRA assets are held in a non-profit voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) Section 501(c)(9).

What is an HRA?

An HRA or health reimbursement arrangement is a type of group health plan that reimburses qualified out-of-pocket medical care expenses and insurance premiums. All contributions, investment earnings, and withdrawals (claims) are tax-free.

The Internal Revenue Code defines an HRA as an arrangement that is funded solely by the employer and reimburses employees (participants) for medical care expenses incurred by the employee, the employee's legal spouse, or qualified children and dependents.

Contributions to an HRA are not subject to federal income tax or FICA tax. Investment earnings credited to an HRA sponsored by a governmental employer or held in a tax-exempt trust are not subject to federal income tax. Reimbursements paid out as qualified medical care expenses to participants, legal spouses, and qualified children and dependents are also excluded from tax. HRA contributions will not be reported on IRS Form W-2 from your employer. You do not report HRA contributions, earnings, or benefit payments (reimbursements) on your individual IRS Form 1040 federal income tax return.

How many separate plan designs are offered under the HRA VEBA Plan?

Based upon current guidance issued under the Patient Protection and Affordable Care Act (PPACA), the HRA VEBA Plan offers two different HRA plan versions: the **Standard HRA Plan** and the **Post-separation HRA Plan**. Each of these plans is designed to be exempt from the annual and lifetime dollar-limit restrictions added by PPACA.

What is the Standard HRA Plan?

The Standard HRA Plan is designed to be "integrated" with each employer's qualified group health plan that complies with the annual and lifetime dollar-limit restrictions added by PPACA. Under the terms of the Standard HRA Plan, a participant's HRA account is considered integrated with the employer's qualified group health plan and eligible to receive employer contributions only if, at the time the participant becomes eligible for such contribution, the participant is eligible to enroll in his or her employer's PPACA-compliant qualified group health plan and either (a) is actually enrolled in or covered by the employer's qualified group health plan or (b) has provided written

confirmation of enrollment in or coverage under another qualified group health plan. Read the **What is a Qualified Group Health Plan?** handout to learn more. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Please note that HRA accounts of participants who are offered coverage through the purchase of one or more individual policies (as opposed to employer-sponsored group coverage), are not considered integrated with the employer's qualified group health plan and are not eligible to receive contributions under the Standard HRA Plan. Also, certain contributions received into the Standard HRA Plan prior to January 1, 2014 are considered "grandfathered" under current PPACA guidance.

What is the Post-separation HRA Plan?

The Post-separation HRA Plan is designed to provide benefits only after a participant separates from service or retires. Post-separation (retiree-only) HRAs are not subject to the annual and lifetime limits restrictions and certain other provisions of the Public Health Service Act. The Post-separation HRA Plan can accept contributions on behalf of any eligible employee, including those who are not eligible to receive contributions to the Standard HRA Plan.

Where can I find the forms I will need for my HRA account?

Most account updates and transactions, including claims submission; changing investment allocations; updating personal and covered individual information; and making or updating other elections can be accomplished after logging in online at **hraveba.org**. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

When and how can I get money out of my HRA account?

Your eligibility to file claims depends on your employer's plan design. The Standard HRA Plan allows participants to begin filing claims while in-service immediately after they enroll. The Post-separation HRA Plan requires participants to separate from service or retire before becoming eligible to file claims.

Your welcome letter, provided to you by the HRA VEBA Plan, confirms your claims eligibility. If you are not immediately eligible to file claims, you will be notified when you do become eligible. Please check with your employer if you have questions about when you may become claims-eligible.

After enrolling and becoming claims-eligible, you can submit claims and required documentation (proof of expense) online after logging in at **hraveba.org** (recommended) or via e-mail, fax, or regular mail as indicated on the paper **Claim Form**. Detailed instructions are contained on the backside of the form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

You may request reimbursement of qualified medical care expenses and/or insurance premiums you have incurred on behalf of yourself, your legal spouse, qualified dependents, and young adult children (through the end of the calendar year in which they turn age 26). Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant and eligible to file claims. Read the **How to File a Claim** handout to learn more. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

What happens if my claim for reimbursement is denied?

If your claim for reimbursement of expenses is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims are discussed in Part III of this document.

What expenses are eligible for reimbursement?

Common qualified out-of-pocket expenses include deductibles, co-pays, coinsurance, prescription drugs, and certain over-the-counter (OTC) items. Eligible insurance premiums include: medical (including marketplace exchange premiums that are or will not be subsidized by the Premium Tax Credit); dental; vision; tax-qualified long-term care (subject to IRS limits); Medicare Part B; Medicare Part D; and Medicare supplement plans.

Section 213(d) of the Internal Revenue Code defines qualified expenses and premiums, in part, as "medical care" amounts paid for insurance or "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body…" Expenses solely for cosmetic reasons generally are not considered expenses for medical care (e.g. face-lifts, hair transplants, hair removal (electrolysis)). Expenses that are merely beneficial to your general health, such as vacations, are not medical care expenses.

Please note the following:

1. IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a section 125 cafeteria plan, or subsidized by the Premium Tax Credit are not eligible for reimbursement. If requesting reimbursement of premiums deducted from your paycheck, you must include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available.
2. If you or your legal spouse has a section 125 health flexible spending account (FSA), you must exhaust the FSA benefits before submitting claims to your HRA account.
3. Claims for over-the-counter (OTC) medicines and drugs (except insulin and contact lens solution) must be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item or service to treat a specific medical condition. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.
4. To be eligible for reimbursement, federal healthcare reform requires that OTC medicines and drugs (except insulin and contact lens solution) be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item or service to treat a specific medical condition. Thus, OTC medicines and drugs such as aspirin, antihistamines, and cough syrup must be prescribed. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

Qualified expenses that may be reimbursed from your HRA will depend upon certain elections you may make to limit your HRA coverage. For example, if you have elected "limited-purpose" HRA coverage (discussed later in this section) or "pre-Medicare limited-scope" HRA coverage (discussed in Part X of this document), the types of expenses eligible for reimbursement are limited as described in those sections.

Read the **Qualified Expenses and Premiums** handout to learn more. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Whose expenses are eligible for reimbursement?

After you become and remain claims-eligible, qualified expenses and premiums incurred by you, your legal spouse, qualified dependents, and young adult children (through the end of the calendar year in which they turn age 26) are reimbursable.

Read the **Definition of Dependent** handout to learn more. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Is there any annual "use-it-or-lose-it" requirement?

No, your unused HRA funds carry over from year to year.

Are there any restrictions?

Withdrawals (claims) may never exceed your available HRA account balance at the time of claim. Depending on your employer's plan design, your HRA account may be limited to post-separation benefits only.

Your welcome letter confirms benefits eligibility and any restrictions. The Post-separation HRA Plan requires you to separate from service or retire before becoming claims-eligible. As a result, you will not be eligible for reimbursement of medical care expenses incurred during any period that you are employed, or subsequently re-employed after separation from service or retirement, with the employer that made contributions on your behalf to the Post-separation HRA Plan.

Can my HRA account automatically reimburse my insurance premiums?

Yes, after enrolling and becoming claims-eligible, you can set up automatic reimbursement of ongoing qualified insurance premiums on behalf of yourself, your legal spouse, qualified dependents, and young adult children (though the end of the calendar year in which they turn age 26). Required information and documentation can be submitted online (recommended) after logging in at **hraveba.org** or via e-mail, fax, or regular mail as indicated on the **Auto Premium Reimbursement** form. Instructions are contained on the backside of the form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

You must provide documentation that includes: name(s) of covered individuals or policy holder; premium amount; policy period; and insurance provider name and address. This information is typically contained on your premium billing notice, statement of insurance, open enrollment notice, pension benefit direct deposit stub, or similar form of documentation. Direct deposit of reimbursements is available and recommended.

Please note the following:

1. IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a section 125 cafeteria plan, or subsidized by the Premium Tax Credit are not eligible for reimbursement. If requesting reimbursement of premiums deducted from your paycheck, you must include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available.
2. Actively-employed participants receiving monthly employer contributions must have a minimum HRA account balance of $2,000 to begin or renew an auto premium reimbursement.

Can any retiree medical premium be reimbursed from my HRA account?

Yes, the cost of any qualified medical insurance plan you elect to use during retirement can be reimbursed from your HRA account, including marketplace exchange premiums that are or will not be subsidized by the Premium Tax Credit, Medicare Part B, Medicare Part D, and Medicare supplement plans. Retiree dental and vision insurance premiums and tax-qualified long-term care insurance premiums (subject to IRS limits) are also eligible for reimbursement.

What is a health savings account (HSA), and can I contribute to an HSA?

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

Can I have both an HRA and an HSA?

Yes, you can have an HRA and an HSA, and you can use either your HRA (if claims-eligible) or HSA to reimburse your qualified expenses (there are no ordering rules). But, if you have a claims-eligible HRA that provides full coverage and you want to become eligible to make or receive contributions to an HSA, current IRS rules require that your HRA coverage be limited as described later in this section.

What is "limited-purpose" HRA coverage, and why might I need it?

"Limited purpose" HRA coverage limits the types of expenses that are eligible for reimbursement from your HRA. Only the following types of expenses are eligible for reimbursement while your HRA coverage is limited: standard dental care services (not related to a medical condition or accident), including dentures; orthodontia; and routine eye exams, contact lenses and eyeglasses (excluding initial lenses and standard frames after cataract surgery). All other expenses incurred while coverage is limited, including qualified insurance premiums, are not covered.

You may need to elect "limited purpose" HRA coverage if you (or a family member covered under your HRA) want to become eligible to make or receive contributions to an HSA. Keep in mind that limiting your HRA VEBA Plan coverage is not the only HSA contribution eligibility requirement. You should check with your HSA provider, but generally any adult can contribute to an HSA if they (1) have coverage under an HSA-qualified high deductible health plan (HDHP); (2) have no other first-dollar medical coverage, which would include a claims-eligible HRA that is a general-purpose or full-coverage HRA (other types of insurance, such as specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance, are permitted); (3) are not enrolled in Medicare; and (4) cannot be claimed as a dependent on someone else's tax return. Your maximum annual HSA contribution amount depends upon your HSA eligibility during the current calendar year. If you become HSA-eligible mid-year, a 12-month testing period may apply to determine your maximum annual HSA contribution. Read the **HSAs, HRAs and FSAs: Effect of HSA Eligibility on Other Account-based Plans** handout to learn more. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

To elect "limited-purpose" coverage, submit a **Limited-purpose Election** form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Electing "limited purpose" HRA coverage may not be necessary if: (1) your HRA is not yet claims-eligible; or (2) you have elected to convert your HRA to "pre-Medicare limited-scope" coverage to become eligible for the Premium Tax Credit as discussed in Part X of this document. For more information, contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

What happens if I take a leave of absence, resign, or retire?

As long as you have met all the requirements to become and remain claims-eligible, you may use your HRA account until funds are exhausted, regardless of your employment status.

What happens if I become re-employed after I separate from service or retire from the employer that made or is making my HRA contributions?

If you have an HRA account under the Standard HRA Plan, you may become re-employed by any employer, including the employer that made or is making contributions to your HRA account, without affecting your claims-eligibility under the Standard HRA Plan.

If you have an HRA account under the Post-separation HRA Plan, your claims eligibility under the Post-separation HRA Plan will continue so long as you remain separate or retired from the employer that contributed to such account. If you subsequently become re-employed with that same employer, claims eligibility for your HRA account under the Post-separation HRA Plan will be turned off while you are re-employed. During the term of your re-employment, you may submit claims for qualified medical care expenses incurred while you were previously separated or retired and claims-eligible. However, medical care expenses incurred during the term of your re-employment are not eligible for reimbursement.

What happens if I get divorced?

In the event that you become divorced or legally separated, your HRA account cannot be split as part of a property settlement agreement. For more information, contact the HRA VEBA Plan's consultant, Gallagher VEBA, at 1-800-888-8322.

What if I pass away before I use up my HRA account?

If you pass away with a positive HRA account balance and are survived by a legal spouse or qualified children (or other dependents as defined by the Internal Revenue Code), they may submit requests for medical care expense reimbursements until your account is exhausted. In the unlikely event you pass away with an unused account balance and have no eligible survivors, the executor of your estate can spend down your account by filing claims for any unreimbursed medical care expenses you may have incurred prior to your death. Remaining funds (if any) after all final claims have been reimbursed would then be forfeited and re-contributed per the terms of the HRA VEBA Plan document or otherwise applied as directed by your employer. IRS Revenue Ruling 2006-36 does not permit the payment of benefits to non-dependent heirs.

How are my HRA funds invested?

You may invest your HRA account using either one of two investment options. **Option A: Choose a pre-mix** allows you to select any one of four professionally-designed pre-mixed asset allocation portfolios designed and monitored by investment professionals. With **Option B: Do-it-yourself**, you can build your own portfolio using any combination of available funds.

Read the **Investment Fund Information** brochure available online at **hraveba.org** to learn more. The **Investment Fund Overview** with investment performance history and fund objectives is also available online and updated quarterly. In addition, you may view up-to-date fund fact sheets and prospectuses on the fund websites, which are listed on the Investment Fund Overview. You should carefully read this information and consult with your personal financial advisor before making investment decisions. HRA VEBA Trust's Board of Trustees, plan consultant, and other service providers do not give investment advice. If you do not make an investment election, your entire HRA account will be allocated to the Stable Value fund, which is the HRA VEBA Plan's default investment.

How often can I change my investment allocation(s)?

You can change your investment allocation as often as once per calendar month. To make a change, log in at **hraveba.org** and click Investments or submit an **Investment Change** form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

After making any investment allocation changes, you should log in at **hraveba.org** and click **Investments** to confirm your changes.

How often will I receive a statement of my HRA account?

Paper participant account statements are mailed in January and July. If you are signed up for e-communication in lieu of paper (recommended), participant account statements are generated quarterly, and the Plan will notify you via email when statements are available for online viewing. To sign up for e-communication, log in at **hraveba.org** and click **My Profile**, or submit an **Account Change** form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

You may request copies of your statements at any time by contacting the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Can I view my HRA account information online?

Yes, you can view your HRA account information online after logging in at **hraveba.org**. Information available online includes account details and preferences, investment performance, contribution and claims history, and participant forms. You can also submit claims, set up auto premium reimbursements, update covered individual information, update account preferences, and update your personal information (name, address, etc.).

What are the HRA VEBA Plan's expenses, and how are they paid?

Plan expenses include claims processing, customer service, account administration, printing, postage, legal, consulting, local servicing, auditing, etc. These costs are paid by a monthly, per participant fee of $1.50 (if claims-eligible) or $1.25 (if not claims-eligible), plus an annualized, asset-based fee of approximately 1.25%. Your HRA account value changes daily based upon activity, which includes investment earnings/losses, contribution and claims activity, and assessment of the annualized, asset-based fee.

To the extent permitted or required by law, certain fees, taxes or other assessments payable to the federal government under health care reform law may also be deducted from participant accounts. The Patient-Centered Outcomes Research Institute (PCORI) fee for the 2014-15 plan year is $2.08 per claims-eligible participant (the fee does not apply to spouses and dependents). The PCORI fee is pro-rated and deducted from claims-eligible participant accounts quarterly (fifty-two cents once every three months). The PCORI fee is imposed on all group health plans by federal health care reform and could increase annually through the 2019-20 plan year.

Who is responsible for developing and managing the HRA VEBA Plan?

The HRA VEBA Plan is offered by the non-profit HRA VEBA Trust, which is managed by a Board of Trustees elected by the plan participants.

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

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

What about amendments or termination of the HRA VEBA Plan?

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

How do I find out more about the HRA VEBA Plan?

Visit **hraveba.org** to learn more about the HRA VEBA Plan. If you have a current HRA account and would like more information, please contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

PART II SUMMARY OF PLAN INFORMATION

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

The name of each of the Plans is:
- HRA VEBA Standard HRA Plan
- HRA VEBA Post-separation HRA Plan

The identification number assigned to the Trust by the Internal Revenue Service is 94-3131623.

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

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

Plan Consultant

Gallagher VEBA, a division of Gallagher Benefit Services, Inc., manages the HRA VEBA Plan's customer care center in Spokane. In addition, Gallagher VEBA's field team provides local on-site service to employers. This includes technical support, plan adoption/renewal assistance, group presentations, etc. In addition, Gallagher VEBA provides specialized consulting services to the Board of Trustees and coordinates all HRA VEBA Trust activities, including the services provided by other third-party vendors.

Investments

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

Board of Trustees

Trustees hold office until resignation, retirement, or removal Replacement trustees are elected by the plan participants in the following two public service agency categories: (1) counties, cities, and towns; and (2) special purpose districts. The following are the current Trustees for each public service agency category:

Special Purpose Districts

Randy Anderson
North Wasco County SD
3632 West 10th Street
The Dalles, OR 97058

Richard Dyer
Clark County PUD
PO Box 8900
Vancouver, WA 98668

Beverly Freeman
Secretary
Chelan County PUD
PO Box 1231
Wenatchee, WA 98807

Counties, Cities & Towns

Doug Detling
Chair
212 Northview Dr
Eagle Point, OR 97524

Debbie Lund
Vice-Chair
City of Aberdeen
200 E. Market Street
Aberdeen, WA 98520

Debby Watts
Treasurer
City of Vancouver
P.O. Box 1995
Vancouver, WA 98668

Each Plan's agent for service of legal process is Russell Greenblatt, Katten Muchin Rosenman LLP, 525 West Monroe Street, Chicago, IL 60661-3693. Notice of legal process may also be delivered to a Trustee or the HRA VEBA Plan at 906 W. 2nd Avenue, Suite 400, Spokane, WA 99201.

A claims-eligible participant account shall be forfeited if, during a period equal to the lessor of the applicable unclaimed property period or three years, at least two communications from the Plan to the Participant have been returned as undeliverable, no contributions to or withdrawals from the participant account have occurred, and no communications or other expressions of interest have been received from or on behalf of the Participant.

PART III PROCEDURE FOR DISPUTED CLAIMS

If your claim is denied in whole or in part, the Plan shall notify you of the denial. Such notice will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman; and a statement describing the availability upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the Plan. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim to the Plan.

After the Plan receives an appeal of a denied claim from you or your authorized representative, the Plan shall deliver the complete file to the Trustees, who shall consider your appeal within 30 days from the time that your appeal was received by the Plan.

In special circumstances, the Trustees may exercise a 15-day extension to review the decision prior to the expiration of the initial 30-day period. The Trustees' decision shall be furnished to you and will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman; and a statement describing the availability upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

The Trustees may determine that a hearing is required to properly consider a claim that has been appealed. In that event, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is appealed. After exhausting the above claims procedures in full, if your request for benefits is denied in whole or in part, you or your authorized representative may request an external review of your denied claim. Any such request for review must be delivered to the Plan no later than four months from the date you received written notification of the Trustees' final denial of your request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the Plan will complete a preliminary review to confirm that you are covered under the Plan, you provided all the information and forms necessary to process the external review, and have exhausted the internal appeals process.

Once the review above is complete, the Plan will notify you in writing of the outcome of its review. If you are not eligible for external review, the notice will inform you of this and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review was incomplete, the notice will describe materials needed to complete the request and you will have the later of 48 hours or the four month filing period to provide the materials needed to complete your filing.

Upon satisfaction of the above requirements, the Plan will assign an independent review organization (IRO) using a method of assignment that assures the independence and impartiality of the assignment process. You may submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by you to the Plan within one (1) business day of receipt. The decision by the IRO is binding on the Plan, as well as on you, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the Plan and to you of its decision to uphold or reverse the benefit denial within no more than forty-five (45) days.

Claims proceedings set forth in this Plan Summary and in more detail in the Plan Document must be strictly adhered to by each claimant and no judicial or arbitration proceedings with respect to any claim for Plan benefits shall be commenced by any such claimant until the appeal has been exhausted in full.

PART IV INVESTMENT FUND INFORMATION

Investment risk

HRA accounts invested in stock or bond funds are not guaranteed and will fluctuate in value. Benefit withdrawals from these types of funds may be worth more or less than your employer's original deposit.

You and your personal investment advisor should periodically review your selected investment fund choice(s). Should your objectives change, or your portfolio does not meet your expectations, you should reevaluate your fund selection(s). You can make any changes online after logging in at **hraveba.org** or by completing an **Investment Change** form. To access paper forms, log in at **hraveba.org** and click **Resources**, or contact the customer care center at **customercare@hraveba.org** or **1-888-659-8828.**

Remember, there have been numerous loss periods in the past among these types of funds, and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, stock or bond investments are suitable primarily as longer-term investments and generally are not used for short-term investing.

Investment Options
You may self-direct the investment of your HRA account balance utilizing one of the following two options:

Option A: Choose a pre-mix
Allows you to select a pre-mixed asset allocation portfolio designed and managed by professionals.

Option B: Do-it-yourself
Build your own portfolio using any combination of available funds.

You can choose only one of these options.

Transfers
You may transfer among the funds once each calendar month. Transfers are generally effective within two to three business days.

Withdrawals
If your HRA account is allocated among multiple investment funds, withdrawals (claims) will be made pro rata based on your current account balance in each fund unless you request otherwise.

Investment funds
You may view information regarding each investment fund including performance, fund prospectuses, and fund fact sheets through secure online account access, and by visiting each fund company's Web site. Detailed information and fund company Web addresses are contained in the **Investment Fund Information** brochure and **Investment Fund Overview** (updated quarterly) at **hraveba.org**.

Investment advice
You are encouraged to seek advice regarding the investment options from your personal financial advisor. The Trustees, Plan consultant, and the other plan service providers do not give investment advice.

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

Where to find more information
More information can be found in the **Investment Fund Information** brochure and **Investment Fund Overview** (updated quarterly) at **hraveba.org**. Fund fact sheets and prospectuses can be viewed through secure online account access, and at each fund's respective Web site.

PART V — COBRA NOTICE, USERRA RIGHTS, AND FMLA NOTICE

COBRA NOTICE
Important information regarding COBRA continuation coverage rights for all participating employees, spouses, and covered children.

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

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

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the Plan.

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

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

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage. In addition, an administrative fee of 2% is added as permitted by COBRA law.

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

Qualifying event notification
The Plan will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits.

When the qualifying event is due to an active participating employee's (1) voluntary or involuntary termination other than for gross misconduct (e.g. separation, retirement, etc.); (2) reduction of hours of employment affecting eligibility; or (3) death, the employer must notify the Plan within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the Plan within 60 days of the occurrence of such event, using the **COBRA Event Notice** form. The completed Notice must be mailed or hand delivered to the Plan. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation; additional documentation may be required. If the Notice is received late, incomplete, or is not submitted as outlined under Notification of Procedures provided on the reverse side of the aforementioned form, no qualified beneficiary will be offered the opportunity to elect COBRA coverage.

COBRA continuation period

The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA.

COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's: (1) voluntary or involuntary termination other than for gross misconduct (e.g. separation, retirement, etc.); or (2) reduction of hours affecting eligibility.

A maximum of up to 36 months is allowed when the qualifying event is due to the participating employee's: (1) legal separation or divorce; (2) death; or (3) when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension

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

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

Information resources

Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the customer care center at **customercare@hraveba.org** or **1-888-659-8828**, or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

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USERRA RIGHTS

If you are claims-eligible and are on military leave that is governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your covered qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the customer care center.

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FMLA NOTICE

The HRA VEBA Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your HRA account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave.

For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

PART VI PRIVACY NOTICE

This Notice Of Privacy Practices Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Introduction

This Privacy Notice (the "Notice") describes the legal obligations of HRA VEBA (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

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

Questions about this Notice or our privacy practices should be directed to the Plan's customer care center, at **1-888-659-8828** or **customercare@hraveba.org**.

Effective date

This Notice is effective January 1, 2015.

Privacy pledge – our responsibility

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

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

How we may use and disclose PHI about you

The following categories describe various ways we use and disclose PHI. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **For payment** (as described in applicable regulations). We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share PHI with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.
- **For health care operations** (as described in applicable regulations). We may use and disclose PHI about you for other Plan operations necessary to run the Plan. For example, we may use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.
- **To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.
- **As required by law.** We will disclose PHI about you when required to do so by federal, state, or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action.
- **To avert a serious threat to health or safety.** We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician.
- **To Employers or Plan Sponsors.** For the purpose of administering the plan, we may disclose PHI to certain employees of your Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization.

- **Military and veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' compensation.** We may release PHI about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.
- **Public health risks.** We may disclose PHI about you for public health activities such as to: (1) prevent or control disease, injury, or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).
- **Health oversight activities.** We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.
- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **National security and intelligence activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

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

Other Disclosures

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

Your rights regarding PHI about you

You have the following rights regarding PHI we maintain about you.

- **Right to inspect and copy.** You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to the Plan. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.
- **Right to amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the Plan including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that: (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
- **Right to an accounting of disclosures.** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

  To request this list or accounting of disclosures, you must submit your request in writing to the Plan. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to request restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, health care operations, or to someone who is involved in your care, or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full. To request restrictions, you must submit a written request to the Plan detailing: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (i.e., your spouse).
- **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the Plan specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.

- **Right to be notified of breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI.
- **Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. You may obtain a paper copy of this Notice on our website at **hraveba.org**. To obtain a paper copy of this Notice, contact the customer care center.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact HRA VEBA Trust's Vice-Chair. All complaints must be submitted in writing. You will not be penalized or otherwise retaliated against for filing a complaint.

Other uses of PHI

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

PART VII MEDICARE PART D NOTICE OF NONCREDITABLE COVERAGE

To Participants, Spouses, Children and Dependents Eligible or Becoming Eligible for Medicare.
Important Notice Regarding Your VEBA (HRA) Prescription Drug Coverage and Medicare Part D.

Introduction

Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by your VEBA (HRA) plan and Medicare Part D prescription drug coverage that became available in 2006 to everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage

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

Consider enrolling in a Medicare drug plan

Prescription drug coverage provided by your VEBA (HRA) plan is limited to your available HRA account balance and is considered "non-creditable." In other words, coverage provided by your VEBA (HRA) plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan. This is important because most likely you will get more help with your drug costs if you enroll in a Medicare drug plan than if you only have prescription drug coverage from your VEBA (HRA) plan.

If you don't enroll when you first become eligible or during the annual open enrollment period, you may pay more and have to wait to enroll

You can enroll in a Medicare drug plan when you first become eligible for Medicare or during the annual open enrollment period from October 15 through December 7. If you drop or lose coverage and don't enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium may go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium may always be at least 19% higher than what most other people pay.

If you or your spouse or dependents are currently Medicare eligible, you need to make a decision

The terms of your VEBA (HRA) plan will not change if you choose to enroll in a Medicare prescription drug plan. Your VEBA (HRA) plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the plan and limited to your available HRA account balance.

When making your decision whether or not to enroll, you should compare your current coverage, including which drugs are covered, with the coverage of the Medicare prescription drug plans offered in your area.

Information resources

More detailed information about Medicare plans that offer prescription drug coverage is contained in the current Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by:

- Visiting www.medicare.gov for personalized help
- Calling your State Health Insurance Assistance Program (see the current Medicare & You handbook for telephone numbers)
- Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at anytime.

PART VIII COORDINATION OF BENEFITS WITH MEDICARE

If you are entitled to Medicare and are claims eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare. To comply with federal law you should file your claims in accordance with these primary and secondary payer rules.

- If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have an active, claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have an active, claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your HRA account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

If you, your spouse, or a dependent are on Medicare, you will be required to use up your HRA account before Medicare will provide future benefits unless: (1) you're retired/separated from service from the employer that made, or is making contributions to your HRA account; (2) your HRA account balance has always been and stays under $5,000; or (3) you've elected limited-purpose HRA coverage. Medicare will provide benefits without requiring that you use up your HRA account first.

MMSEA Section 111 Reporting.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA plans for plan years beginning on or after October 1, 2010, requires the Plan for your HRA account to report specific information about Medicare beneficiaries who have other group coverage (such as your HRA coverage). To comply with this federal law, the policies and procedures of the Plan will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims in your HRA account. In addition, in submitting claims for reimbursement for coverage under your HRA account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact the customer care center or you can call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

PART IX EXEMPTION FROM ANNUAL LIMIT RESTRICTIONS

The Affordable Care Act prohibits health plans from applying dollar limits on coverage for certain benefits.

Your HRA plan has been designed base upon exemptions from these annual limits restrictions and in accordance with guidance issued by the Internal Revenue Service and HHS. Accordingly, withdrawals under your HRA plan are limited to your available HRA account balance. This means coverage provided to you by this plan may not reimburse for all the health care expense you may incur.

If you have any questions or concerns about this notice, contact the plan consultant, Gallagher VEBA, at 1-800-888-8322.

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

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

Oregon Insurance Division - Oregon Health Connect
350 Winter St. NE, Salem, OR 97309
1-855-999-3210
health.connect@state.or.us

PART X PREMIUM TAX CREDIT ELIGIBILITY

You may qualify for the Premium Tax Credit starting in 2014 if you (or a family member) purchase health insurance through a state or federal marketplace exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your current out-of-pocket premium amount, or you can wait until you file your tax return. The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through a marketplace exchange. Go to www.irs.gov/uac/The-Premium-Tax-Credit for more information.

If you have a claims-eligible HRA account, purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit, you should know:

1. **Premiums subsidized by the Premium Tax Credit may not be reimbursed from your HRA account.** In other words, you cannot use your tax-free HRA funds to reimburse premiums that are subsidized by the Premium Tax Credit. IRS rules do not permit you to receive two tax advantages on the same expense.

2. **For any month during which you are claims-eligible and retain a positive balance in your HRA account, you may not qualify for the Premium Tax Credit for that month unless you take certain action.** If you are claims-eligible and retain a positive HRA account balance, or receive additional contributions to your account, then it may make sense for you to use up, limit, or forfeit your account, as described in more detail below, before taking the Premium Tax Credit.

But first, keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you are not eligible for the Premium Tax Credit and do not need to use up, limit, or forfeit your HRA account:

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

What can I do if my HRA account is the only thing keeping me from becoming eligible for the Premium Tax Credit?
If you are claims-eligible and your HRA coverage is the only reason you cannot qualify for the Premium Tax Credit, you may consider:

1. **Using up your HRA account before taking the Premium Tax Credit.** You do not have to take the Premium Tax Credit right away. You could first use up your HRA account to reimburse your non-subsidized premiums (and any other qualified medical care expenses). Then, you could begin taking the Premium Tax Credit in advance or wait and claim it on your tax return, but only for premiums you paid after using up your HRA account. Keep in mind that, if you receive any additional HRA contributions after using up your HRA account, you will lose eligibility for the Premium Tax Credit again for any months during which you retain a positive balance in your account.
2. **Electing Pre-Medicare Limited-scope Coverage.** If you make this election, your HRA account will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations) until you become Medicare-eligible either by age or permanent disability. Pre-Medicare Limited-scope coverage is designed as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal health care reform law. **This election will remain in force with respect to any expenses you incur after the date you make the election and until you turn age 65 (or earlier upon death or Medicare eligibility due to permanent disability), at which time you may convert your HRA account back to full coverage for all types of qualified medical expenses and premiums.**

   The **Pre-Medicare Limited-scope Election** form is available online after logging in at **hraveba.org** or upon request from the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.
3. **Electing to Forfeit Future Reimbursements.** In lieu of first using up your HRA account or electing Pre-Medicare Limited-scope coverage, you have the right under the HRA VEBA Plan and under federal health care reform law to permanently forfeit or give up all future reimbursements from any amounts currently held in your HRA account or that may be contributed into your account prior to or during any period for which you receive the Premium Tax Credit. **This election is permanent and means that you are giving up your HRA account and forfeiting future reimbursements from the Plan.**

The **Permanent Waiver Election** form is available online after logging in at **hraveba.org** or upon request from the customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

Consider Your Options Carefully
You should consider your options carefully and seek advice from a tax professional. The best decision may vary depending on your unique circumstances, including the amount of your HRA account balance compared to the amount of your Premium Tax Credit.

For example, if you are eligible for a large Premium Tax Credit and have a small HRA account balance, you may decide to quickly use up or forfeit your HRA account balance in order to take advantage of the Premium Tax Credit. But, if you are only eligible for a small Premium Tax Credit and have a larger HRA account balance (or expect to receive future HRA contributions), you may decide to either (1) elect Pre-Medicare Limited-Scope Coverage and take the Premium Tax Credit right away or (2) delay taking the Premium Tax Credit and continue to use your HRA account for all of your out-of-pocket expenses and unsubsidized premiums until it runs out.

Keep in mind that if you take advance Premium Tax Credit payments without first using up, limiting, or forfeiting your HRA account as described above, you will likely be ineligible for the Premium Tax Credit and may be required to pay it back when you file your tax return for the year.

Where Can I Get More Information?
This section is intended to provide you with general information about the Premium Tax Credit and the options available to you under the Plan. **More information can be found online at www.irs.gov/uac/The-Premium-Tax-Credit.**

If you have questions, you should contact the plan consultant, Gallagher VEBA, at 1-800-888-8322. A client consultant or service representative is available to assist you. The HRA VEBA Plan and its agents, including Gallagher VEBA, do not give legal or tax advice.