CALIFORNIA FIREFIGHTERS
BENEFIT TRUST
Administered By: Benefit Programs Administration
T: (844) 353-7839 | F: (562) 463-5894 | E: CFBT@bpabenefits.com
www.FirefighterTrust.org

NOTICE TO RETIREE PARTICIPANTS

TO: All Retiree Participants in the Medical Expense Reimbursement Plan of the California Firefighters Benefit Trust

FROM: Board of Trustees, California Firefighters Benefit Trust

RE: Reminder: Annual Disclosure of Premiums and Monthly Verification of Premiums for Claims Payment

DATE: January 15, 2023

As you may recall, last year IRS rulings required the Trust Office to implement monthly verifications of premiums. To accomplish this, the Trust required all retiree participants receiving benefits to:

1) Submit the one-time Annual Disclosure Form (attached) highlighting all health premiums the participant will be responsible for during the upcoming year;

   - Include with the above form, documentation from the insurance company or third-party indicating: insurance carrier; type of coverage; effective date; and premium amount; and

2) Each month submit verification of actual premium paid for the current month. This will need to be accomplished prior to the 5th of each month. This documentation must show each of the following items for each month of insurance coverage that you request reimbursement of premiums:

   1) Type of insurance coverage, e.g., medical, dental, vision insurance;
   2) Month of coverage that the premium paid for;
   3) Amount of the premium; and
   4) Proof of payment of the premium by a Beneficiary of the Plan.

Once the monthly verification has been received by the Trust Office, and assuming all requests are deemed consistent with applicable rules and laws, you will be reimbursed the amount indicated on your Annual Disclosure Form, up to your maximum allowable benefit. If your request changes, you'll need to submit a revised form indicating your new amount or alternatively, you may submit the Medical Expense Reimbursement Claim Form (available on our website) for additional amounts or expenses not related to premiums. As a reminder, per IRS rules this is a reimbursement trust; expenses incurred in January will be reimbursed in February.

For additional information on the above, please visit our website at www.FirefighterTrust.org and select Resources > Plan Documents. Under Notices, you will find two Summary of Material Modifications (SMM) which go into more detail.

Thank you in advance for your cooperation.

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If you have any questions about this Notice or would like a copy of the Summary Plan Description, or the full Plan, please contact the Trust Office at phone: 844.353.7839 or email CFBT@bpabenefits.com.

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ANNUAL DISCLOSURE OF PLANNED MONTHLY PREMIUM REIMBURSEMENT

The premiums listed and amount requested below indicate your total premium expenses and the amount you intend to request each month during the upcoming year. Once this form is submitted, all that is required will be monthly proof of payment verification.

Plan Participant Name: _____

Spouse's Name: _____

Address: _____

_____

Date of Retirement or Termination of Employment: _____

Date of Birth: _____ Social Security Number: _____

Daytime Phone #: _____ E-mail Address: _____

1) Reimbursement Limited to Premium Paid. As a Beneficiary in the Medical Expense Reimbursement Plan (Plan) of the California Firefighters Benefit Trust (Trust), I understand that I am entitled to a monthly reimbursement benefit for insurance premiums and/or medical expense payments that I make up to the amount of my benefit. I understand that the benefits paid by the Trust cannot exceed the actual premiums and medical expenses paid by the Beneficiary and will not exceed my monthly benefit and/or Individual Account balance (if applicable). I have elected to receive reimbursement of health (medical, dental, prescription drug, vision) insurance premiums, as stated on page two.

2) Change in Premiums. I understand that, based on the information I provide herein, the Trust will make payments directly to me to reimburse me for my premium payments. I agree to notify the Trust within 30-days of termination or reduction of any of the claimed insurance premiums. If I fail to do so, I will be obligated to reimburse the Trust for any overpayments to me, as well as to pay the Trust for penalties and interest.

3) Monthly Documentation of Premiums. I understand that premium reimbursement will not commence until I have signed this Annual Disclosure Form and it is received by the Trust Office, along with written documentation from the insurance carrier or another third party showing: coverage type; effective date; and premium amount. **I further understand that I must submit the actual proof of expense, e.g., written documentation from a third party for each month of premium for which I request reimbursement.** The claim form is only submitted annually, unless my premium amount changes mid-year, but documentation of premium expenses is submitted for each monthly premium prior to reimbursement. I understand that I can submit the documentation monthly or in batches, but it must be submitted before a claim for reimbursement will be paid and it must be submitted prior to the claim deadline of the 5th of each month.

4) Benefits May Be Adjusted. I understand that my Benefit Level is determined based upon the Unit Multiplier set and reviewed periodically by the Trustees, and that the Trustees may adjust the Unit Multiplier or benefit formula, or other provisions of the Plan, from time to time, which may affect my Benefit Level.

I am enrolled in the following plan(s) with the following premiums:

☐ Medical: _____

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Dental: _____

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Vision: _____

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Drug: _____

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Other: _____

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

Total Monthly Premium Reimbursement Requested $_____

Not to exceed participants monthly benefit and/or Individual Account (if applicable) balance.
I understand requests that exceed my monthly benefit will be paid out of my Individual Account.

5) Income Tax Deductions. I understand that these benefit payments are not taxable, and therefore, expenses reimbursed are not allowed as deductions when filing my individual income tax return.

6) Premium Payment to Insurance Carrier. I understand that I am responsible for all premium payments to the insurance carrier(s) and that the Trust will reimburse me - not the insurance carrier.

7) Claims Limited to Covered Expenses. If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Plan Section 1.10, I understand that the Trust may pursue recoupment of overpaid benefits and penalties for failure to withhold taxes.

8) Fraudulent Claims. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, e.g., failure to advise the Trust of termination of coverage or change in premium.

9) Suspension of Benefits During Re-employment with Participating Employer. I affirm that I am not currently employed by a Participating Employer (including part-time or contract work) and was not employed by a Participating Employer when the attached expenses were incurred. I affirm that I do not intend to start employment with a Participating Employer within the next year, and if I do, I will inform the Trust Office prior to my first day of work.

I certify under penalty of perjury that the information I have given above is true and correct, and that I have read this Form.

_____ _____

Eligible Retiree or Surviving Spouse/Child Signature Date