Livermore Class Action Settlement Administration and Education Fund, Inc.
Retiree Health Reimbursement Arrangement

January 1, 2021

PLAN NAME:	Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement
PLAN SPONSOR:	Livermore Class Action Settlement Administration and Education Fund, Inc.
PLAN EFFECTIVE DATE:	January 1, 2021
PLAN NUMBER	501
PLAN ADMINISTRATOR	Livermore Class Action Settlement Administration and Education Fund, Inc.

Livermore Class Action Settlement Administration and Education Fund, Inc., a California nonprofit corporation, hereby establishes for certain Eligible Class Members a health reimbursement arrangement (HRA) plan. The Plan Administrator has contracted with Extend Health, LLC to provide recordkeeping and administrative services with respect to the Plan.

This document contains certain definitions and general administrative provisions that govern the Plan.

The provisions on the following pages are a part of this Plan. Such provisions alone, including any attachments, schedules, appendices, and incorporated documents, constitute the agreement under which payments will be made, and are a part of this Plan. Such attachments, schedules, appendices, and incorporated documents may change from time to time, in the sole discretion of the Plan Administrator.

This Plan is established to implement the Final Approval Order (as defined herein), which states: "Petitioners, The Regents, and Class Members shall consummate the settlement according to the terms of the Settlement Agreement. The Settlement Agreement, and each and every term and provision thereof, shall be deemed incorporated herein as if explicitly set forth herein and shall have the full force and effect of an order of this Court," Final Approval Order, ¶ 10; and which further states: "The Parties and Settlement Administrator are hereby directed to implement this Final Approval Order and Judgment and the Settlement Agreement in accordance with the terms and provisions thereof, including processing the payments provided for under the Settlement Agreement." Id. ¶ 17.

The Settlement Agreement provides that the Class Representatives (as defined in the Settlement Agreement) shall form a Voluntary Employees' Beneficiary Association (VEBA), Settlement Agreement ¶ V-A-4-(i), which "will be used to provide funds for the Class Members' purchase of health insurance or any other benefit permissible under IRC § 501(c)(9)." Id. ¶ III-A-36.

The VEBA is established to distribute the Supplemental Payment to Eligible Class Members until the earlier of December 31, 2040, or only 1,000 or fewer Eligible Class Members are living, at which time remaining funds are distributed to Class Members who are still living. Settlement Agreement, ¶ III-A-36, V-A, subparts 3, 5-7, 14; Schedule C. The Supplemental Payment augments health and welfare benefits provided to Eligible Class Members by the Lawrence Livermore National Security Health and Welfare Benefit Plan for Retirees. See Id. ¶ IV-A, subparts 3-4, V-A-3.

The Final Approval Order further provides that "this Court retains continuing jurisdiction over the Parties and the Class Members for the administration, consummation, and enforcement of the terms of the Settlement Agreement, including the Court's monitoring and reporting functions set forth in the Settlement Agreement, pursuant to California Rule of Court 3.769(h) and California Code of Civil Procedure § 664.6." Final Approval Order, ¶ 30.

The Plan Sponsor intends to continue this Plan until the earlier of December 31, 2040, or only 1,000 or fewer Eligible Class Members are living, pursuant to the terms of the Final Approval Order and Settlement Agreement. However, the Plan Sponsor at any time and from time to time may amend, change, revoke or terminate the Plan without the consent of any Covered Person or any other persons entitled to receive payment of benefits under the Plan, subject to the continuing jurisdiction of the Superior Court.

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ARTICLE I

INTRODUCTION

1.1 Purpose of the Plan

The purpose of this Plan is to provide Eligible Class Members (as determined under Article III) with the opportunity to participate in a health reimbursement arrangement (HRA) as described in Attachment A, which is incorporated by reference into this Plan.

This Plan is a health and welfare benefit plan within the meaning of Section 3(1) of ERISA and for all purposes under ERISA.

1.2 Interpretation and Law

The Plan shall be construed and interpreted in a manner consistent with the requirements of Code Sections 105 and 106, the applicable sections of the Code, ERISA, HIPAA, the Genetic Information Nondiscrimination Act, and any other applicable law and any amendments thereto and any regulations issued thereunder, and subject to the continuing jurisdiction of the Superior Court.

1.3 Effective Date

The Plan is hereby effective as of January 1, 2021.

ARTICLE II

DEFINITIONS

The following words and phrases as used herein shall have the following meanings unless a different meaning is plainly required by the context.

2.1 **Benefit Credits** means Supplemental Payments that have been credited under the Plan.

2.2 **Case** means Requa/Moen v. Regents of Univ. of Cal., Alameda Superior Court Case No. RG 10530492.

2.3 **Class Member** has the meaning set forth in the Final Approval Order and the Settlement Agreement.

2.4 **Code** means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.5 **Covered Person** means an Eligible Class Member who is covered under this Plan.

2.6 **Effective Date** means January 1, 2021. The Attachment to the Plan may be changed, at the discretion of the Plan Administrator, without having to formally amend the main section of the Plan.

2.7 **Eligible Class Member** means a Class Member described in the Final Approval Order.

2.8 **Enrollment Period** means the enrollment or any other period that provides for an Eligible Class Member to make an election under the LLNS Plan.

2.9 **ERISA** means the Employee Retirement Income Security Act of 1974, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.10 **Final Approval Order** means the Final Approval Order and Judgment dated April 10, 2020, pursuant to which the Superior Court approved the Settlement Agreement.

2.11 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to

any section or subsection of HIPAA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.12 **LLNS Plan** means the Lawrence Livermore National Security Health and Welfare Benefit Plan for Retirees.

2.13 **Named Fiduciary** means the Plan Administrator and any other person designated as such in writing.

2.14 **Participant** means any Eligible Class Member who participates in the Plan in accordance with Article III, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

2.15 **Plan** means this Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement, as described in this document, together with any and all amendments, supplements, attachments, appendices, and incorporated documents hereto.

2.16 **Plan Administrator** means the Plan Sponsor or any person(s) or entity(ies) whom it appoints, through action of its board of directors or a designated subcommittee of the board of directors, to serve as plan administrator, as such term is defined under ERISA.

2.17 **Plan Sponsor** means Livermore Class Action Settlement Administration and Education Fund, Inc., a California nonprofit corporation, or any successor thereto.

2.18 **Plan Year** means a period commencing on January 1 and ending on December 31.

2.19 **Qualified Medical Child Support Order (QMCSO)** means an order which creates or recognizes the existence of a child's right to health benefits under the LLNS Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

a. the name and last known mailing address of an Eligible Class Member and the name and last known mailing address of each child covered by the order,
b. a reasonable description of the type of coverage to be provided by the LLNS Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,
c. the period to which the order applies, and
d. each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with ERISA Section 609.

2.20 **Settlement Administrator** means ARCHER Systems, LLC.

2.21 **Settlement Agreement** means, with respect to the Case, the Stipulation of Class Action Settlement and Release dated on or about December 11, 2019.

2.22 **Superior Court** means the Superior Court of the State of California, County of Alameda.

2.23 **Supplemental Payments** has the meaning set forth in the Settlement Agreement.

2.25 **Uniformed Services** means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

2.26 **USERRA** means the Uniformed Services Employment and Reemployment Rights Act, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.27 **VEBA** means the Livermore Retirees Health Insurance Trust, a voluntary employee beneficiary association established under Code Section 501(c)(9).

2.28 **VEBA Trustee** means Argent Trust Company or successor trustee.

Whenever used in this Plan, a masculine pronoun or adjective shall be deemed to include the masculine and feminine gender, and a singular word shall be deemed to include the singular and the plural, unless the context clearly indicates otherwise.

ARTICLE III

PARTICIPATION

3.1 Eligibility

Any Eligible Class Member will be eligible to participate in this Plan.

3.2 Determination of Eligibility by Plan Administrator

The determination of a Class Member's eligibility to participate in the Plan shall be made by the Settlement Administrator, and the Settlement Administrator's good faith determination shall be binding and conclusive upon all persons.

3.3 Commencement of Participation

An Eligible Class Member shall become a Participant under the Plan subject to the Eligible Class Member's valid enrollment in one of the group health plans or individual health plans maintained under the LLNS Plan that is described in the enrollment guide for the LLNS Plan, as in effect from time to time.

3.4 Elections and Changes in Elections for Benefits

The election of the benefit options shall be made under and pursuant to the LLNS Plan. Benefits for a Plan Year under this Plan are determined based on such election under the LLNS Plan.

3.5 Contribution Basis

a. Covered Persons may not contribute to their Health Reimbursement Arrangement under the Plan.
b. The Plan Sponsor will arrange for contributions directly to each third-party administrator to fund the benefits provided under the Plan for the Participants, to the extent determined by the Settlement Administrator and/or VEBA Trustee, in such amounts and at such times as the Settlement Administrator and/or VEBA Trustee, in accordance with any applicable funding policy and methods of the Plan, shall from time to time direct, including, but not limited to, contributions needed to pay current benefits, and to pay expenses.

3.6 Effective Dates and Conditions

In order to participate and receive benefits under this Plan, a person must meet any additional participation requirements under this Plan and must also enroll in the LLNS Plan pursuant to Section 3.3.

3.7 Rescission of Coverage

A Participant shall not perform an act, practice, or omission that constitutes fraud relating to his or her coverage under the Plan or coverage sought on behalf of another individual nor make an intentional misrepresentation of material fact with regard to his or her coverage under the Plan or coverage sought on behalf of another individual. A Participant's coverage under the Plan shall be rescinded if the Participant or a person seeking Plan coverage on behalf of the Participant:

a. performs an act, practice, or omission that constitutes fraud relating to his or her Plan coverage; or
b. makes an intentional misrepresentation of material fact regarding his or her coverage under the Plan.

The Plan shall provide 30 days advance written notice to each Participant who would be affected by a rescission before coverage under the Plan is rescinded. A rescission of Plan coverage shall be effective as of the date of the act, practice, or omission constituting fraud or the date of the intentional misrepresentation of material fact on which the rescission of coverage is based.

3.8 Termination Coverage

Coverage under this Plan of any Participant will terminate in accordance with the rules and procedures set forth in Attachment A.

3.9 Continuation/Conversion

Notwithstanding Section 3.8, opportunities to continue and/or convert coverage under this Plan shall be provided in accordance with applicable state and federal law, including the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and USERRA.

3.10 QMCSO

The Plan Administrator shall adopt procedures respecting QMCSOs in accordance with ERISA Section 609. Such procedures shall comply with ERISA Section 609 and shall be administered in a nondiscriminatory manner by the Plan Administrator.

ARTICLE IV

BENEFITS

4.1 Generally

Each Participant who is an Eligible Class Member will participate, subject to such Participant's enrollment in a medical plan maintained under the LLNS Plan pursuant to Section 3.3.

The Plan may be the subject of separate trust agreement, or contract, the terms of which are incorporated in the Attachment to this Plan.

ARTICLE V

CLAIMS PROCEDURES

5.1 Claims Procedure

The claim procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in Attachment A.

5.2 Claims and Appeals Procedures

Benefits that are covered under this Plan shall be paid in accordance with the rules and procedures set forth in Attachment A, which shall govern the claims and appeals procedures in accordance with the requirements of ERISA to the extent applicable.

5.3 Timeliness of Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation has been submitted to the Plan Administrator or any third-party administrator designated by the Plan Administrator.

5.4 Recovery of Payments

The Plan has the right to deduct from any benefits properly payable under this Plan the amount of any payment that has been made:

a. in error; or
b. pursuant to a misstatement contained in a proof of loss; or
c. pursuant to an intentional misstatement made to obtain coverage under this Plan within two years after the date such coverage commences (explained further in Section 3.7 of the Plan, “Rescission of Coverage”); or
d. with respect to an ineligible person; or
e. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (e) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Such deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to such Participant or any person covered or asserting coverage. Any such reduction in benefit shall be subject to the review and appeal process as set forth in Attachment A.

ARTICLE VI

PLAN ADMINISTRATION

6.1 **Plan Administrator** The Plan Administrator is to supervise the administration of the Plan. It shall be a principal duty of the Plan Administrator to ensure that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan and subject to the continuing jurisdiction of the Superior Court. Subject to and in accordance with any applicable requirements of law, the Plan Administrator shall have the full discretionary power to administer the Plan in all of its detail. For this purpose, the Plan Administrator's powers and duties include, but shall not be limited to, the following authority in addition to all other powers provided by this Plan, all subject to the continuing jurisdiction of the Superior Court:

a. interpret the terms and provisions of the Plan, its good faith interpretation thereof to be final and conclusive on all persons claiming benefits under the Plan;
b. make and enforce such rules and regulations it deems necessary or proper for the efficient administration of the Plan including the establishment of any claims procedures that may be required by the provisions of any applicable law;
c. perform all acts necessary to meet the reporting and disclosure obligations imposed by ERISA or the Code, if any;
d. delegate, in writing, specific responsibilities for the operation and administration of the Plan to any employees, agents, or third parties it deems advisable;
e. appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in the administration of the Plan;
f. maintain records and accounts pertaining to the Plan;
g. receive, review and keep on file the annual reports of the Plan, if any;
h. determine eligibility under the Plan; such good faith determination to be binding and conclusive on all persons; and
i. correct any defect, supply any omission, or reconcile any inconsistencies in the manner and to the extent it considers proper to carry the Plan into effect.

6.2 **Records and Reports of the Plan Administrator**

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Plan Sponsor. The Plan Administrator shall prepare and submit to the Plan Sponsor an annual report which shall include such information as the Plan Administrator deems necessary or advisable.

6.3 **Named Fiduciaries**

a. The Plan Administrator, and any other person designated as such in writing, shall be the "Named Fiduciaries" of the Plan for the purposes of ERISA Section 402(a)(1), and shall have only those duties, responsibilities and obligations

(referred to collectively as "fiduciary duties") as specifically are given them under the Plan or as otherwise are imposed by applicable law. The fiduciary responsibilities of the named fiduciaries shall be exercisable separately and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such named fiduciary. However, the named fiduciaries may by written agreement allocate fiduciary responsibilities among themselves.

b. Section 402 of ERISA also authorizes the Plan Sponsor to designate one or more named fiduciaries under the Plan, each with complete authority to review all claims for benefits and determine all issues under the Plan with respect to which it has been designated named fiduciary. In exercising its fiduciary responsibilities with respect to the Plan, each named fiduciary designated hereunder shall have the fullest discretionary authority permitted under law to determine whether and to what extent employees and their eligible dependents are entitled to Plan benefits and to construe disputed or doubtful terms. Each named fiduciary shall be responsible for construing and interpreting the particular provisions of the Plan for which it has been designated a named fiduciary in accordance with ERISA and the terms of any contracts or policies entered into between the Plan Sponsor and the named fiduciary. Each named fiduciary designated hereunder shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.
c. The designation of any entity as a named fiduciary under the Plan shall not create any right or expectation on the part of such entity to continue in such position for any particular period of time. The Plan Sponsor may, in its sole and absolute discretion and at any time, terminate, replace, substitute or otherwise remove any named fiduciary designated under the Plan.
d. Each named fiduciary may appoint and/or employ a person or persons other than a named fiduciary under the Plan to render advice with regard to any responsibility such fiduciary has under the Plan. Any such appointment or employment shall be solely at the expense of that named fiduciary and shall be effective only with the written consent of the Plan Sponsor.

6.4 Examination of Records

The Plan Administrator shall make available to each Participant such of his records under the Plan as pertain to him, to the extent not prohibited under applicable law, for examination at reasonable times during normal business hours.

6.5 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

6.6 Indemnification of Plan Administrator

As permitted by law, and as limited by any written agreement between the Plan Sponsor and the Plan Administrator, the Plan Sponsor agrees to indemnify and to defend any employee, individual, officer, or director serving as the Plan Administrator or as a member of a committee designated as Plan Administrator, (including any employee or former employee, individual, officer or director who formerly served as Plan Administrator or as a member of any such committee) against all liabilities, claims, loss, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Plan Sponsor) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

6.7 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as are required under ERISA shall be available to any Participant or Eligible Class Member at reasonable times during normal business hours at the business office of the Plan Administrator or the business office of the Plan Sponsor.

6.8 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates in writing another person to be such agent and communicates such information to Participants (such as in a summary plan description).

6.9 Administrative Expenses

The Plan Sponsor will arrange for the payment of all expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist or other person who shall be employed by the Plan Administrator in connection with the administration.

6.10 Delegation

The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Provider and/or Claims Administrator) the authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

6.11 Bonding

To the extent required by ERISA or other applicable law, every fiduciary of the Plan, and every person handling funds of the Plan or any component thereunder

shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law.

6.12 **Several Fiduciary Liability**

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

ARTICLE VII

AMENDMENT AND TERMINATION

7.1 Authority for Amendment and Termination

The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan, in whole or in part, by written instrument without prior notice, subject to the continuing jurisdiction of the Superior Court. Any amendment to modify, amend, or terminate the Plan shall be affected by the board of directors. A summary of Plan changes describing any material changes or modifications to the Plan will be distributed to all Participants. Written notice of any termination of the Plan and the effective date of such termination shall be provided to Participants, subject to the continuing jurisdiction of the Superior Court.

7.2 Effect of Changes

All changes to this Plan shall become effective as of a date established by the board of directors, except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by such person(s), regardless of the effective date of the change. Upon termination or discontinuance, contributions relating to the Plan shall terminate.

7.3 Discontinuance of Contributions

It is the expectation that the Plan Sponsor will continue to arrange for the payment of contributions under this Plan, but the continuation of such payments is not assumed as a contractual obligation of the Plan Sponsor; and the right is reserved by the Settlement Administrator and/or VEBA Trustee at any time, and for any reason, to reduce, suspend or discontinue contributions under this Plan, subject to the continuing jurisdiction of the Superior Court.

ARTICLE VIII

GENERAL PROVISIONS

8.1 Entire Contract

This Plan, including all supplements and appendices hereto, and the applications of the Covered Persons, if any, constitutes the entire contract of coverage under this Plan between the Plan Sponsor and the Covered Persons, subject to the continuing jurisdiction of the Superior Court.

8.2 Written Notice

Any written notice required under this Plan shall be deemed received by a Covered Person if sent by regular mail, postage prepaid, to the last address of such Covered Person on the records of the Plan Administrator.

8.3 Information to be Furnished

Participants shall provide the Plan Sponsor and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms (or in compliance with the procedures) as may be required by the Plan Administrator.

8.4 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof, or the payment of any benefits, shall be construed as giving to any Participant or Eligible Class Member or other person any legal or equitable right against the Plan Sponsor, any officer, agent or other employee of the Plan Sponsor, Plan Administrator or member of the Plan Administrator, except as expressly provided herein or as provided by applicable federal law.

8.5 No Vested Interest

Except for the right to receive any benefit payable under the Plan, no person has any right, title, or interest in or to the assets of the Plan Sponsor because of the Plan.

8.6 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or

have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

8.7 Applicable Law

This Plan shall be construed, administered and enforced according to the applicable federal laws governing employee benefit plans and, to the extent not inconsistent therewith, in accordance with the laws of the California. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

8.8 Restriction on Forum and Venue

Notwithstanding anything herein to the contrary, an action related to benefits under the Plan (within the meaning of ERISA Section 502(a)(1)(B)) shall be brought only in the Superior Court. This court shall have the exclusive jurisdiction to resolve any such claim. Any other action under ERISA shall be brought only in the United States District Court for the Northern District of California. This court shall have the exclusive jurisdiction to resolve any such claim.

8.9 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

8.10 Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

8.11 Nonalienation of Benefits

To the extent permitted by law, the rights or interests of any Participant or his beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits

hereunder shall be void. Notwithstanding the foregoing, the Plan Administer may arrange for payment of Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

8.12 Gender

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

8.13 Headings

The headings used in this Plan are for the purpose of convenience of reference only. Covered Persons are advised not to rely on any provisions because of the heading. In all cases, the full text of this Plan will control.

8.14 Disability or Death

If the Plan Administrator shall find that any Eligible Class Member to whom or for whom any amount is payable under this Plan, is unable to care for his affairs because of illness or accident, or is a minor, or has died, then any payment due him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may, if the Plan Administrator so elects, be paid to his spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall be a complete discharge of the liability of the Plan Sponsor, the Plan Administrator, and the Plan.

8.15 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no employee, retiree, Eligible Class Member or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon all persons having or claiming to have any interest in this Plan.

8.16 Plan Funding

Benefits are funded solely by contributions arranged by the Plan Sponsor.

8.17 Inability to Locate Payee

If the Plan Administrator is unable to arrange for payment to any Participant or other person to whom a payment is due under the Plan because he cannot

ascertain the identity or whereabouts of such Participant or person after reasonable efforts have been made to identify or locate such Participant or person (including a notice of the payment so due) mailed to the last known address of such Participant or other person as shown on the records of the Plan Sponsor, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited according to the administrative procedures of the Plan or as otherwise required by any applicable state or federal law.

8.18 Tax Effects

Neither the Plan Sponsor nor the Plan Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Covered Person will be treated as excludable from gross income for state or federal income tax purposes.

8.19 Authorization to Collect Electronic Data

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, ERISA or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted.

8.20 Quality of Health Services

The selection by the Plan Sponsor of the coverages that may be financed through the Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any dental, health, or vision care service provider, nor does the Plan Sponsor assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances. Each Participant for whom enrollment is provided under any coverage agrees, as a condition of such enrollment, that such Participant will look only to appropriately certified or licensed providers, and not to the Plan Sponsor, for benefit related services, and further that the Participant releases, discharges, indemnifies, and holds harmless the Plan Sponsor, the Plan Administrator, their respective employees, officers, directors, and shareholders, and all other persons associated with them, with respect to all matters relating to (a) the quality, sufficiency, and appropriateness of health, prescription drug, dental, vision or employee assistance services provided, (b) the failure by any provider to provide any service needed, or to properly obtain informed consent prior to rendering or withholding any service, regardless of the reason for such failure, (c) professional malpractice by a service vendor or provider, or (d) the failure of any insurance carrier to pay for any care for which the Participant or other service recipient believes himself entitled to reimbursement.

8.21 Legal Remedy

Before pursuing a legal remedy, an individual claiming benefits or seeking redress under the Plan shall first exhaust all claims, review and appeal procedures available or required under the Plan. Because the Plan is governed by ERISA, an individual has the right to bring a civil action under Section 502(a) of ERISA if he or she is not satisfied with the outcome of the claims, review and appeals procedures available or required under the Plan. An individual that files his or her claim within the required timeframe and who exhausts his or her required claim, review and appeal rights may sue over his or her claim (unless he or she has executed a release of his or her claim). An individual must commence such a suit within 12 months after completing the appeals process, and no more than two years after the event that prompted the original claim, or such the right to bring such an action will be lost.

8.22 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

8.23 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

ARTICLE IX

HIPAA PRIVACY AND SECURITY

9.1 HIPAA Privacy Compliance

The Plan shall comply with applicable requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, (collectively "HIPAA") with respect to the benefits under the Plan which meet the definition of a "group health plan" as defined by HIPAA, specifically the health reimbursement account described in Attachment A. Compliance shall include, but not be limited to the following:

a. **Plan Sponsor Uses and Disclosures**. The Plan shall establish and determine the permitted and required uses and disclosures of Protected Health Information ("PHI," as defined by HIPAA) by the Plan Sponsor, provided that such permitted and required uses and disclosures may not be inconsistent with the HIPAA regulations.
b. **Plan Sponsor Obligations.** The Plan shall disclose PHI to the Plan Sponsor only upon the Plan Sponsor's agreement that the Plan Sponsor shall:
    a. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
    b. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
    c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
    d. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by HIPAA of which the Plan Sponsor becomes aware;
    e. Make PHI available in accordance with the provisions of HIPAA granting individuals access to their own PHI contained in the Plan's designated record set;
    f. Make PHI available for amendment by the individual who is the subject of the PHI and incorporate any amendments to such person's PHI in accordance with relevant HIPAA provisions;
    g. Make available the information required to provide an accounting of PHI disclosures to an individual covered by the Plan in accordance with relevant HIPAA provisions;
    h. Make the Plan Sponsor's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
    i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such

information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Provide for adequate separation between the Plan and the Plan Sponsor, as set forth below.

The Plan Sponsor hereby agrees to abide by the above obligations and to certify to the Plan that the Plan has been amended to incorporate the foregoing provisions.

a. **Adequate Separation.**
    a. Only those employees or classes of employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to the PHI to be disclosed, including any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business
    b. The Plan shall restrict the access to and use by such employees or classes of employees or other persons under the control of the Plan Sponsor to plan administrative functions that the Plan Sponsor performs for the Plan.
    c. The Plan shall provide an effective mechanism for resolving any issues of noncompliance with the provisions of this by such employees and other persons under the control of the Plan Sponsor.
b. **Plan Disclosures.** The Plan may:
    a. Disclose PHI to the Plan Sponsor for purposes of the Plan's administrative functions that the Plan Sponsor performs consistent with the provisions of this Plan;
    b. Not permit a health insurance issuer or Health Maintenance Organization ("HMO") with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this;
    c. Not disclose, and not permit a health insurance issuer or HMO to disclose, PHI to the Plan Sponsor as otherwise permitted by this unless the disclosure is included in the Plan's Notice of Privacy Practices distributed to Plan Participants; and
    d. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
    e. Summary Information. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:
    f. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
    g. Modifying, amending or terminating the Plan.
c. **Enrollment Information**. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.

9.2 HIPAA Security Compliance

The Plan shall comply with the applicable requirements of HIPAA's Security Standards and the implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, with respect to the programs under the Plan which meet the definition of a "group health plan" as defined by HIPAA, specifically the health reimbursement arrangement described in Attachment A. Compliance shall include, but not be limited to the following:

a. **Plan Obligations**. The Plan shall disclose Electronic Protected Health Information ("ePHI") to the Plan Sponsor only upon the Plan Sponsor's agreement that the Plan Sponsor shall:
    a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;
    b. Ensure that any agents to whom the Plan Sponsor provides ePHI agree to implement reasonable and appropriate security measures to protect the ePHI; and
    c. Report to the Plan any security incident (as defined by HIPAA) or breach (as defined by HIPAA) of PHI of which the Plan Sponsor becomes aware.
    d. Enrollment, disenrollment and summary health information shall not be subject to these requirements.
b. **Adequate Separation**. The Plan Sponsor shall ensure that the provisions of the Plan are supported by reasonable and appropriate security measures to the extent the identified employees or classes of employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to ePHI.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, this Plan has been executed on the 14th day of May, 2021.

LIVERMORE CLASS ACTION SETTLEMENT ADMINISTRATION AND EDUCATION FUND, INC.

By: _____

Jay C. Davis, President

ATTACHMENT A

Livermore Class Action Settlement Administration and Education Fund, Inc.
Retiree Health Reimbursement Arrangement

Summary Plan Description

Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Livermore Class Action Settlement Administration and Education Fund, Inc. has established the Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement (the "Plan") for the benefit of Eligible Class Members.

This Plan is established to implement the Final Approval Order (as defined herein), which states: "Petitioners, The Regents, and Class Members shall consummate the settlement according to the terms of the Settlement Agreement. The Settlement Agreement, and each and every term and provision thereof, shall be deemed incorporated herein as if explicitly set forth herein and shall have the full force and effect of an order of this Court," Final Approval Order, ¶ 10; and which further states: "The Parties and Settlement Administrator are hereby directed to implement this Final Approval Order and Judgment and the Settlement Agreement in accordance with the terms and provisions thereof, including processing the payments provided for under the Settlement Agreement." *Id*. ¶ 17.

The Settlement Agreement provides that the Class Representatives (as defined in the Settlement Agreement) shall form a Voluntary Employees' Beneficiary Association (VEBA), Settlement Agreement, ¶ V-A-4-(i), which "will be used to provide funds for the Class Members' purchase of health insurance or any other benefit permissible under IRC § 501(c)(9)." *Id*. ¶ III-A-36.

The VEBA is established to distribute the Supplemental Payment to Class members until the earlier of December 31, 2040, or until 1,000 or fewer members of the class are living, whichever occurs first, at which time remaining funds are distributed to Class Members who are still living. Settlement Agreement, ¶ III-A-36, V-A, subparts 3, 5-7, 14; Schedule C. The Supplemental Payment *augments* health and welfare benefits provided to eligible Class Members by the Lawrence Livermore National Security Health and Welfare Benefit Plan for Retirees. *Id*. ¶ IV-A, subparts 3-4, V-A-3.

The Final Approval Order further provides that "this Court retains continuing jurisdiction over the Parties and the Class Members for the administration, consummation, and enforcement of the terms of the Settlement Agreement, including the Court's monitoring and reporting functions set forth in the Settlement Agreement, pursuant to California Rule of Court 3.769(h) and California Code of Civil Procedure § 664.6." Final Approval Order, ¶ 30.

The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code of 1986, as amended ("Code"), as well as a health reimbursement arrangement as defined in Internal Revenue Service Notice 2002-45. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2).

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description ("SPD") is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor's offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Sponsor.

Note that capitalized terms used in this SPD that are not otherwise defined herein have the meaning set forth in the Plan or the Plan Information Index. Please note that "you," "your" and "my" when used in this SPD refer to you.

PART I
GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to implement the Final Approval Order and the Settlement Agreement by reimbursing Participants for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant's taxable income.

Q-2. Who can participate in the Plan?

Eligible Class Members may participate in the Plan. Eligible Class Members are members of the class defined by the Final Approval Order. Eligible Class members who become covered under the Plan, as explained in Q-3, are called "Participants."

In addition, you are *not* eligible to participate in the Plan unless you are classified by the Settlement Administrator as an individual who satisfies the eligibility requirements.

Q-3. When do I actually become a Participant in the Plan?

An Eligible Class Member becomes a Participant in the Plan on the *later* of the Effective Date of the Plan or the date that he or she is determined to be eligible by the Settlement Administrator. You must enroll in a group health plan or individual health plan maintained under the LLNS Plan in order to become and/or remain a Participant in this Plan.

Q-4. How does the Plan work?

Supplemental Payments will be credited to HRA Accounts by the Plan Sponsor in the amount and at the times determined by the Settlement Administrator and/or VEBA Trustee pursuant to the Final Approval Order and Settlement Agreement. Supplemental Payments for the current Plan Year are set forth on Exhibit I hereto. One HRA Account will be established for all Participants in your family. Benefit Credits will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her HRA Account. Note that the law does *not* permit Participants to make any contributions to their HRA Accounts.

An HRA Account is a bookkeeping account on the Plan Sponsor's records; it is not funded and does not bear interest or accrue earnings of any kind.

Q-5. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities);
    - Medications are considered Eligible Medical Expenses *only if* they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin.
    - This Plan only reimburses expenses for covered Part D prescription drugs to the extent that Catastrophic Coverage Reimbursement applies as set forth in the Plan Information Appendix. If Catastrophic Coverage Reimbursement does not apply, then no reimbursement for covered Part D prescription drugs will be made.

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Individual insurance policy premiums purchased through Via Benefits or an affiliate, including, major medical individual insurance premiums, stand-alone dental and/or vision premiums, Medicare Advantage premiums, Medicare Part D premiums, and Medicare supplemental insurance premiums.

Some examples of common items that are *not* Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues (unless specific requirements are satisfied); and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items may or may not be Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is designed to address what medical expenses are deductible on Form 1040, Schedule A, *not* what is reimbursable under a health reimbursement arrangement.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix. The Plan Administrator (and its delegates) solely determine what is an Eligible Medical Expense.

Eligible Medical Expenses are "incurred" when the medical care is provided, *not* when you or your Eligible Dependent are billed, charged or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g. pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may *not* be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred for covered Part D prescription drugs;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA;

- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- any other expenses specifically identified as excluded in the Plan Information Appendix.

Q-6. When do I cease participation in the Plan?

If you are an Eligible Class Member, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Class Member for any reason;
- if you were eligible for Medicare, the date thereafter that you cease to be eligible for Medicare (unless you remain eligible under another provision of the Plan);
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of "incurred," see Q-5.) You have ***180 days*** after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

Q-7. What happens if I do not use all of the amounts credited to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be *carried over to subsequent Plan Years*.

Q-8. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and submit it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred and (e) name of provider. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

The Claims Submission Agent shall make reimbursement payments by direct deposit.

The Claims Submission Agent may establish an auto reimbursement process for the payment of certain health insurance premiums. Auto reimbursements shall not be considered to be claims for benefits and shall not be subject to the claims procedures in Q-9. In establishing and operating any auto reimbursement process, the Claims Submission Agent may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be claims for benefits and shall not be subject to the claims procedures in Q-9.

Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall *automatically forfeit **18 months** from the date set forth on the check or from the date the payment was otherwise attempted*. If the Participant or other authorized person contacts the Claims Submission Agent prior to the 18-month forfeiture time frame, the Claims Submission Agent shall cancel and void the original check or payment and shall re-issue a new check.

If the Participant or other authorized person does not contact the Claims Submission Agent prior to the 18-month forfeiture time frame, the unclaimed check or unclaimed payment shall be voided and the amount of the voided check or payment shall be considered to be Benefit Credit as of such date and shall be credited to the Participant's HRA Account as of such date. This means that such Benefit Credit may be used to reimburse Eligible Medical Expenses incurred from and after the date of such Benefit Credit in accordance with the terms of the Plan on such date. If the Participant's HRA Account has been closed as of the date such Benefit Credit would otherwise be made, the Benefit Credit shall not be made, but rather shall be forfeited.

Q-9. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix *no later than **180 days** after receipt of the denial notice*. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal *no later than **60 days** after the Plan Administrator receives your request for appeal*. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in court until you have exhausted these appeals procedures.

Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to HRA Account benefits, the claim or action must be brought *within **18 months** of the date of the denied appeal*.

- For all other claims (including eligibility claims), the claim or action must be brought *within **two years** of the date when you know or should know of the actions or events that gave rise to your claim*.

- An action shall be brought in connection with the Plan only as provided under the Plan. This court shall have the exclusive jurisdiction to resolve any such claim.

Q-10 What happens if I die?

The HRA Account shall continue and the other Participants in your family can continue to submit Eligible Medical Expenses for reimbursement. If you die with no other Participants in your family, your HRA Account is immediately forfeited upon death, but the your estate or representatives may submit claims for Eligible Medical Expenses incurred by you before your death. *Claims must be submitted within **180 days** of his or her death*.

Q-11. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Plan Sponsor cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-12. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you will be required to refund the overpayment or erroneous reimbursement.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-13. How long will the Plan remain in effect?

Although the Plan Sponsor generally expects to maintain the Plan until the earlier of December 31, 2040, or until 1,000 or fewer Eligible Class Members are living. The Plan Sponsor has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, and the Settlement Administrator and/or VEBA Trustee may reduce or eliminate the Supplemental Payments in the future, in each case subject to the continuing jurisdiction of the Superior Court.

Q-14. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

Q-15. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II
ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- 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 insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your Sponsor, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit as provided in the Plan. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in the as provided in the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit as provided in the Plan. If it should happen that plan fiduciaries misuse 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 as provided in the Plan. 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 (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III
LEGAL NOTICES

Health Insurance Portability and Accountability Act

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or "Protected Health Information" ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" or "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is materially changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for plan administrative purposes or as otherwise permitted by federal law. This notice only applies to Protected Health Information or PHI as defined in the applicable HIPAA privacy rules.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for plan administrative purposes or as otherwise permitted by law. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the protected health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; or
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the

information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notwithstanding the above, and to the extent provided in applicable law, the Plan shall not use or disclose your PHI that is classified as genetic information for purposes of any underwriting activity.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person on your behalf has paid the health care provider and you have not requested reimbursement from the Plan.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a "Designated Record Set" or "DRS." The DRS is the group of records maintained by or on behalf of the Plan contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Sponsor that duplicates information maintained by a Plan business associate in its DRS.

The Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing.

If you exercise your right to access your PHI, the Plan will respond to your request within 30 days, subject to a one-time extension of an additional 30 days. In the case of an extension, the Plan must provide you with a written explanation for the delay and the date by which it will respond to your request.

The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

C. Right to Amend PHI

If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (except where you are unable to request an amendment from the person or entity that created the PHI because the person or entity is no longer available); (2) the Plan determines the information to be accurate or complete; (3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, a description of your right to submit a statement of disagreement and a description of your right to file a complaint with the Plan or with the Department of Health and Human Services.

D. Right to Receive an Accounting of PHI Disclosures

You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an

authorization; or (4) disclosures made more than six years ago (or the inception of the Plan, whichever is later).

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. This time period may not be longer than six [6] years and may not include any disclosures of PHI made before the inception of the Plan. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: Notice of Breaches of Unsecured PHI

Under HIPAA, the Plan and its business associates, are required to maintain the privacy and security of your PHI. The goal of the Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as "breaches." If a breach affects you and is related to unencrypted PHI, the Plan or its applicable business associate will notify you of the breach and the actions taken by the Plan or the business associate to mitigate or eliminate the exposure to you.

Section 5. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of

Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 7. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

PLAN INFORMATION APPENDIX

GENERAL PLAN INFORMATION

Name of Plan:	Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement
Effective Date:	January 1, 2021
Name, address, and telephone number of the Plan Sponsor:	Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement c/o Sinclair Law Office ROTUNDA BUILDING, SUITE 160 300 FRANK H. OGAWA PLAZA OAKLAND, CALIFORNIA 94612 510.465.5300
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Livermore Class Action Settlement Administration and Education Fund, Inc. Retiree Health Reimbursement Arrangement c/o Sinclair Law Office ROTUNDA BUILDING, SUITE 160 300 FRANK H. OGAWA PLAZA OAKLAND, CALIFORNIA 94612 510.465.5300
Agent for Service of Legal Process:	Andrew Thomas Sinclair, Esq. ROTUNDA BUILDING, SUITE 160 300 FRANK H. OGAWA PLAZA OAKLAND, CALIFORNIA 94612 510.465.5300
Sponsor's federal tax identification number:	85-3395704

Plan Number:	501
Plan Year:	January 1 – December 31
Third Party Administrator: **Claims Submission Agent:**	Via Benefits P.O. Box 981156 El Paso, TX 79998-1156 (833) 939 – 1210 Fax (866) 886 – 0878 My.ViaBenefits.com/LCASE
Funding:	Benefits are funded pursuant to the Final Approval Order and Settlement Agreement.

Exhibit I
2021 Supplemental Payments

2021 Non-Medicare 65 and Over Retiree Supplemental Payments							
	KAISERN	KAISERS	APLUS	APPO	ACORE	AHDHP	AEPO
EEONLY	$2,183	$2,183	$7,287	$3,400	$0	$34	$2,218
SPONLY	$2,417	$2,417	$8,038	$3,727	$0	$62	$2,468
EESPOUSE	$4,600	$4,600	$15,313	$7,127	$0	$72	$4,673
EECHILD	$3,951	$3,951	$13,125	$6,107	$0	$65	$4,017
SPCHILD	$4,171	$4,171	$13,863	$6,460	$0	$104	$4,266
EEFAMILY	$6,368	$6,368	$21,151	$9,848	$0	$115	$6,471
CHONLY	$62	$62	$5,143	$2,942	$0	$1,205	$2,269

2021 Non-Medicare Pre-65 Retiree Supplemental Payments							
	KAISERN	KAISERS	APLUS	APPO	ACORE	AHDHP	AEPO
EEONLY	$80	$80	$6,435	$3,667	$0	$1,519	$2,843
SPONLY	$84	$84	$7,075	$4,036	$0	$1,682	$3,143
EESPOUSE	$164	$164	$13,523	$7,717	$0	$3,200	$5,972
EECHILD	$143	$143	$11,579	$6,609	$0	$2,749	$5,124
SPCHILD	$133	$133	$12,231	$6,978	$0	$2,899	$5,411
EEFAMILY	$227	$227	$18,667	$10,645	$0	$4,418	$8,267
CHONLY	$62	$62	$5,143	$2,942	$0	$1,205	$2,269

2021 Medicare Eligible Supplemental Payments		
	Via Benefits	Kaiser Senior Advantage
Retiree only	$598	$606
Spouse only	$598	$606
Retiree + Spouse	N/A	$1,213