



Dear ACERA Retiree,

Alameda County Employees' Retirement Association (ACERA) established a Health Reimbursement Arrangement (HRA) for the benefit of retirees of the County of Alameda and its Participating Employers. The purpose of the HRA plan is to reimburse eligible retirees, enrolled in individual plans through Extend Health, Inc. (OneExchange), for their medical and prescription drug plan premiums as well as deductibles and co-pays. The plan is intended to qualify as a self-insured medical reimbursement plan as provided by the Internal Revenue Code.

ACERA is dedicated to maintaining the privacy of your health information and is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information.

Enclosed is ACERA's Summary Plan Description for Health Reimbursement Arrangement (SPD). The SPD includes questions and answers regarding coverage, legal notices, your access to your Protected Health Information (PHI), ACERA's disclosure of PHI, and plan terms. ACERA initially offered this plan effective February 1, 2013 to Medicare eligible retirees. Effective January 1, 2016, the plan was expanded and made available to all eligible retirees who live outside of ACERA's group medical plan coverage area. The attached SPD has been revised to reflect the new group of eligible retirees.

In the future, any material changes to this SPD will be distributed within 60 days of the effective date.

ACERA Staff

Enclosure

SUMMARY PLAN DESCRIPTION

FOR

HEALTH REIMBURSEMENT ARRANGEMENT

Adopted and Effective Date: February 1, 2013
Last Amended Date: January 1, 2016

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INTRODUCTION

Alameda County Employees' Retirement Association ("ACERA" or, the "Plan Sponsor") has established a Health Reimbursement Arrangement (the "Plan") for the benefit of retirees of the County of Alameda, California, and its Participating Employers (collectively, the "Employer"). The purpose of the Plan is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed. 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, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. However, ACERA cannot guarantee that benefits provided under this Plan will qualify in this way.

The material provisions of the Plan as of January 1, 2016 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 Plan 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 Plan Sponsor.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

PART I GENERAL INFORMATION ABOUT THE PLAN

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

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-5) 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 though ACERA cannot guarantee that they will be excluded.

Q-2. Who can participate in the Plan?

Retired employees of the Employer are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree as defined in Section 1 of the Plan Information Appendix. Eligible Retirees, who become covered under the Plan, as explained in Q-3, are called "**Participants**."

Note that you are not eligible to participate in the Plan unless you are classified by the Plan Sponsor as a former employee of the Employer who satisfies the eligibility requirements, even if you are determined by a court or governmental agency to be or to have been a former common law employee of the Employer.

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

An Eligible Retiree becomes a Participant in the Plan if he or she has satisfied all of the following requirements:

- Completed 10 years of ACERA Service (as defined in the Plan) or retired with a service connected disability;
- Obtained an individual health insurance policy through Extend Health, Inc. (OneExchange); and
- Completed any enrollment forms or procedures required by the Plan Administrator.
- If not Medicare eligible, the Eligible Retiree must reside outside of ACERA's group medical plan coverage area.

Q-4. How does the Plan work?

A separate HRA Account will be established for each Participant.

Benefit Credits will be credited to HRA Accounts by ACERA in the amount and at the times specified in Sections 7 and 8 of the Plan Information Appendix and 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 merely a bookkeeping account on ACERA's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan will be paid from ACERA's Internal Revenue Code Section 401(h) account but only to the extent that assets are available in that account.

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

For purposes of the Plan, Eligible Medical Expenses are limited to the following items only:

- Premiums for medical insurance and prescription drug insurance maintained through Extend Health, Inc. (OneExchange).
- Copayments and deductibles for medical care and prescription drug expenses covered by such insurance maintained through Extend Health, Inc. (OneExchange).

Eligible Medical Expenses also do not include any that is not described in section 213(d)(1) of the Internal Revenue Code. 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.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Eligible Medical Expenses are "incurred" when the

medical care is provided, not when you are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) 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 your HRA Account:

- 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 not specifically identified as reimbursable in the first paragraph under this Q-5.

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

As an Eligible Retiree, you will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by the Employer as an active employee;
- the date of your death;
- the effective date of any amendment terminating your eligibility under the Plan;
- the date the Plan is terminated;
- the date that the 401(h) account is terminated; or
- the date that the assets in the 401(h) account are no longer available.

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 credits allocated 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 forfeited on April 1 of the following Plan Year.

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

You must complete a reimbursement form and mail or fax it to the **Claims Submission Agent** for all reimbursable copays and deductibles 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; and (d) the amount incurred. 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. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

You must submit requests for reimbursement of Eligible Medical Expenses by March 31 following the Plan Year in which the expense is incurred.

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.

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 must 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 reason(s) for the denial and the Plan provisions on which the denial is based.

The decision of the Plan Administrator on any such appeal is final and binding on all parties.

Q-10 What happens if I die?

If you die, any balance in your HRA Account is forfeited upon your death, provided that your estate or representative may submit claims for Eligible Medical Expenses incurred by you before your death. Any such claims must be submitted within 180 days following your 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, ACERA cannot guarantee the tax treatment of any benefit payment. Please consult your own tax advisor if you have any questions about this.

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 to the Plan. If you do not refund the overpayment or erroneous reimbursement ACERA may have to report it as taxable income to you.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Plan. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt and may take all necessary and appropriate steps to collect.

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

ACERA has the right to modify or terminate the program at any time for any reason, including but not limited to the right to change the classes of persons eligible for participation, to change the categories of expenses eligible for reimbursement, to change the amounts credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

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 any other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by your Employer, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

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
LEGAL NOTICES**

Mothers' and Newborns' Health Protection Act

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

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 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 administrative plan purposes as permitted by federal law.

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.

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

The Plan also may disclose PHI to the Plan Sponsor for administrative purposes permitted by law and related to treatment, payment or health care operations. 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 health

information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

The Plan and its business associates may 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.

The Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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. In addition, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

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; and
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Other 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.

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.

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

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. “*Designated Record Set*” includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used by the Plan entity to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan at the address provided at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan at the address provided at the end of this Notice.

D. Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to April 14, 2004; or (4) pursuant to your authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will

charge a reasonable, cost-based fee for each subsequent accounting. You or your personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan at the address provided at the end of this Notice.

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

You have a right to obtain 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 internet 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. 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 5. 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 6. 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:	Alameda County Employees' Retirement Association Health Reimbursement Arrangement
Name, address, and telephone number of the Plan Sponsor:	ACERA 475 14 th Street, Suite 1000, Oakland, CA 94612
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.	ACERA 475 14 th Street, Suite 1000 Oakland, CA 94612 510-628-3000 Attn: HRA Plan Administrator
Plan Sponsor's federal tax identification number:	<u>94-6130325</u>
Plan Year:	Initial Plan Year: February 1, 2013 – December 31, 2013 Thereafter: calendar year
Third Party Administrator:	Extend Health, Inc. (OneExchange) 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 (888) 427-8730 www.ExtendHealth.com/employer
Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	PayFlex Systems USA, Inc. Extend Health HRA P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
Funding:	Benefits will be paid from ACERA's Internal Revenue Code Section 401(h) account but only to the extent that assets are available in that account.

PLAN TERMS

1. Eligible Retiree: Eligible Retiree means:

- (a) A former common law employee of the Employer who has retired and has satisfied the following requirements:
- (1) Completed 10 Years of ACERA Service (as defined in the Plan) or retired with a service-connected disability.
 - (2) Enrolled in a health insurance policy through Extend Health, Inc. (OneExchange).
- (b) The following former common law employees are not Eligible Retirees: N/A.
-

2. Dependents:

- (a) A Dependent also includes a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree until (1) the date of, (2) the end of the month in which occurs, or (3) the end of the calendar year in which occurs, the child's _____th birthday (may not exceed 26).
- (b) N/A.

3. Benefit Credits for Eligible Dependents:

- (a) Yes
- (b) No

4. Eligible Dependent: An Eligible Dependent may be a Participant in the Plan: **No.**

- (a) only if and when the Eligible Retiree becomes a Participant
- (b) regardless of whether the Eligible Retiree is a Participant, but the Dependent must not participate in another group health plan sponsored by the Plan Sponsor/Employer

5. Insurance Coverage Exception: In lieu of obtaining an individual health insurance policy through Extend Health, Inc. (OneExchange), an Eligible Retiree may establish that he or she: **N/A. No exceptions.**

- (a) Has health coverage under TRICARE
- (b) Has health coverage under a policy or plan provided by his or her spouse's employer
- (c) Resides outside the United States

6. Account Structure:

- (a) *Combined Account.* Only one HRA Account will be established for all Participants in a single family and all credits for such family members will be credited to such HRA Account.
- (b) X *Separate Accounts.* A separate HRA Account will be established for each Participant within a single family.

7. Benefit Credit:

- (a) The following annual amount will be credited on behalf of Participants who are Eligible Retirees:
 - (1) X Discretionary, to be determined in the sole discretion of the Plan Sponsor each Plan Year
 - (2) Fixed Dollar Amount of \$_____
- (b) The following annual amount will be credited on behalf of Participants who are Eligible Dependents: N/A
 - (1) Discretionary, to be determined in the sole discretion of the Plan Sponsor each Plan Year.
 - (2) Fixed Dollar Amount of \$_____ for Dependent Spouses.
 - (3) Fixed Dollar Amount of \$_____ for Dependents other than Spouses.
 - (4) (Specify formula):_____

8. Timing of Benefit Credit: Benefit Credits will be credited to HRA Accounts as follows:

- (a) One time on (insert date):_____
- (b) X On the first day of each Plan Year
- (c) On the first day of each calendar quarter (i.e., one-fourth of the annual Benefit Credit 9 will be credited each quarter)
- (d) On the first day of each calendar month (i.e., one-twelfth of the annual Benefit Credit will be credited each month)

9. Eligible Medical Expense Exclusion: Eligible Medical Expenses do not include the following: Any expenses other than premiums for medical insurance and prescription drug insurance maintained through Extend Health, Inc. (OneExchange) and copayments and deductibles for medical care and prescription drug expenses covered by such insurance maintained through Extend Health, Inc. (OneExchange) Eligible Medical Expenses also do not include any amount that is not described in section 213(d)(1) of the Internal Revenue Code.

10. Carryover of Accounts: Credits remaining in an HRA Account at the end of a Plan Year (after the expiration of the claims run-out period) shall:

- (a) be forfeited on April 1 of the following Plan Year
- (b) be carried over to the following Plan Year to reimburse Participants for Eligible Medical Expenses incurred during subsequent Plan Years
- (c) be carried over to the following Plan Year, up to a limit of \$_____

11. Death: Participants who are Eligible Dependents shall continue to receive Benefit Credits after the Eligible Retiree's death: **N/A**

- (a) Yes
- (b) No

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