

**KAISER ALUMINUM SALARIED RETIREES VEBA PLAN
QUALIFIED REIMBURSEMENT REQUEST FORM: 2018 PLAN YEAR**

Send form to: Delta Fund Administrators, LLC, Third Party Administrator

Mailing Address:
Delta Fund Administrators, LLC
P.O. Box 2308
Stockton, CA 95201-2308

Telephone, Fax, and Email:
Phone Toll Free: (888) 344-8322
Fax: (209) 940-5135
[Email: veba@deltafund.com](mailto:veba@deltafund.com)

- **2018 Available Benefit.** The maximum 2018 benefit for each Family Unit is \$4,700.
- **Enrollment.** If you are eligible to participate in the Plan, you must first enroll to become a participant. Only participants enrolled in the Plan by December 31, 2018 are eligible to receive reimbursement of their 2018 expenses.
- **Qualifying Expenses.** Qualifying expenses include Medicare Part B and D premiums, as well as health insurance premiums paid on an **after-tax** basis for coverage during 2018 under a health care plan or policy that provides medical, prescription drug, dental, or vision benefits. Health care premiums also include premiums paid for coverage under a "qualified long term care insurance contract."
- **Filing Deadline is December 31, 2019.**
- **Filing Instructions.** Please refer to Attachment A (General Eligibility Information) for further information.

Participant Information

Name of claimant: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number _____ Email: _____

If a conservator, guardian or legal representative is the Family Unit Representative, a copy of the court order, official letter of appointment or power of attorney appointing the Family Unit Representative as conservator, guardian or legal representative must be submitted with this form.

Retiree's Name: _____ SSN: _____ Date of Birth: _____

Date of Retirement: _____

Spouse's Name (if applicable): _____ Date of Marriage to Retiree: _____

Spouse's SSN: _____ Spouse's Date of Birth: _____

Dependent Name (if applicable): _____ SSN: _____ Date of Birth: _____

Please attach additional sheet(s) with name, social security number and date of birth for additional dependents on claim.

Amount of Premiums Claimed

Amount of Medicare Part B premiums claimed: \$ _____

Amount of Medicare Part D premiums claimed: \$ _____

Other health care premiums paid **after-tax** claimed: \$ _____

Premiums for qualified long term care insurance contract claimed: \$ _____

TOTAL REIMBURSEMENT REQUESTED: \$ _____

**PLEASE ATTACH
ALL PROOFS OF COVERAGE
AND PROOFS OF
PREMIUMS PAID TO
THIS CLAIM FORM**

Change in Marital Status Notification

Should your marital status change, please complete and return the following to the Plan:

Please check the appropriate box: Retiree -OR- Spouse

Type of Event (*select one*):

Death - Enter Date: _____ Name of deceased: _____

Please provide copy of death certificate

Divorce - Enter Date: _____ Name of divorced spouse: _____

Remarriage - Enter Date: _____ Name of new spouse: _____

Waiver of Medicare Coverage

Please complete this section for any Plan participant who is eligible for but has not enrolled in Medicare.

_____ is age 65 or over, but was not enrolled in Medicare Part A during the entire 2018 Plan Year.

You must sign the below certification to receive reimbursement.

CERTIFICATION

By signing this form, the Family Unit Representative certifies:

(a) the information contained in and attached to this form is complete and correct to the best of his or her knowledge and belief,

(b) to the extent that reimbursement of any Medicare B premiums is being made, that coverage under Medicare Part B remains in force and that all premiums for such coverage have been paid as of the date of this form, either directly or by deduction from Social Security benefits,

(c) to the extent that reimbursement of any premiums for employer-provided health coverage is being made, that such premiums were paid on an **after-tax** basis,

(d) to the extent that reimbursement of any premiums for long term care insurance is being claimed, that such premiums were paid on an **after-tax** basis for a "qualified long-term care insurance contract," as such term is defined by Internal Revenue Code Section 7702B(b),

(e) no expenses submitted for reimbursement have been or will be claimed as a deduction on a personal income tax return,

(f) any individual age 65 or over whose expenses are being submitted for reimbursement by the Plan is enrolled in Medicare Part A or has completed the Waiver section above,

(g) with respect to any Surviving Spouse, such spouse certifies that the marriage date provided on this form is accurate, and that he or she has not remarried, and that he or she became the Family Unit Representative upon the death of the retiree, and

(h) he or she understands that the consequences of providing incorrect or incomplete information on this form may include, but are not limited to, loss of benefits under the Plan and reporting to the applicable tax authorities.

Signature of Member or Family Unit Representative: _____ Date signed: _____

Attachment A

General Eligibility Information and Claims Filing Instructions

General Eligibility Information

To be eligible to participate in the Plan as a retiree, you must have begun to accrue credited service with the Company under the Kaiser Retirement Plan (KRP) prior to February 1, 2002, and have as well as be eligible under the original Kaiser Aluminum Salaried Retirees Medical Plan (i.e. full retirement under KRP). For a full explanation of eligibility rules, see the summary plan description. Only participants enrolled in the Plan by the last day of the applicable Plan year are eligible to receive reimbursement of qualifying expenses for that Plan year. Please request an Enrollment Form from the Third Party Administrator, Delta Fund Administrators, LLC ("Delta"). Claims for a Plan year filed after December 31 of the subsequent year will not be eligible for reimbursement.

For your spouse to be eligible for benefits, your marriage must have taken place prior to the first day of the month following your retirement date. In the event of divorce or legal separation, your spouse will no longer be eligible for benefits under the Plan. In the event you remarry, your new spouse will not be eligible for benefits.

To be eligible to participate as a Surviving Spouse, you must have been legally married to the Retiree for at least the full 12-month period prior to the Retiree's death. A Surviving Spouse who remarries is no longer eligible for participation in the Plan as of the remarriage date.

Family Unit Representative

- The Family Unit Representative is the individual who certifies the Reimbursement Request. The Family Unit Representative is the Retiree, if living and competent to conduct his or her own affairs.
- If the Retiree is not living or is not competent to conduct his or her own affairs, then the Family Unit Representative is the Retiree's Spouse, if living and competent to conduct his or her own affairs.
- If the Retiree's Spouse is not living or is not competent to conduct his or her own affairs, then the Family Unit Representative is one of the Retiree's adult children competent to conduct his or her own affairs, if any.
- If a conservator, guardian or legal representative has been appointed for the Retiree, if living, or for the Retiree's Spouse, if the Retiree is not living, then the conservator, guardian or legal representative is the Family Unit Representative. A copy of the court order, official letter of appointment or power of attorney appointing the Family Unit Representative as conservator, guardian or legal representative shall be filed with the Third Party Administrator.

Proof of Claim

Each person for whom this claim is being filed must provide the following:

Medicare Part B Premiums. For reimbursement of Medicare Part B premiums:

- Attach a copy of your 2018 Social Security Benefit Statement Form 1099-SSA (issued in January 2019 for benefits received during 2018); **OR**
- Attach a copy of the annual letter from Social Security titled "Your New Benefit Amount"; **AND**
- Attach a copy of your Medicare card showing Part B coverage.

Medicare Part D Premiums. For reimbursement of Medicare Part D premiums:

- Attach a copy of your Benefit Verification Letter from Social Security Administration (setting forth 2018 Social Security year-to-date benefits and deductions); **OR**
- Attach a copy of your 2018 Social Security Benefit Statement Form 1099-SSA (issued in January 2019 for benefits received during 2018).

Other Health Care Premiums Paid with After-Tax Dollars. This includes premiums paid to (a) an insurance company, (b) a health maintenance organization (HMO), or (c) an employer-sponsored health plan through after-tax payroll deduction to obtain medical, prescription drug, dental, or vision benefits under a health care plan or policy. For reimbursement of other health care premiums:

- Attach a copy of your 2018 health care card; **AND**

- Attach copies of proof of premiums paid during 2018 as follows:
 - Copies of cancelled checks for payment of premiums, **OR**
 - Copy of a letter from the insurance provider stating your name, address and the total amount of premiums paid for 2018 coverage, **OR**
 - Copy of the relevant portion of a bank or credit card statement including your name and address confirming the date and amount of the monthly premium payment for 2018 coverage, **OR**
 - Copy of a letter from the insurance provider stating your name and address, advising the premium amount automatically deducted from your bank for 2018 coverage, **OR**
 - Copies of all invoices from your health care plan or insurer showing payment of 2018 monthly premiums, **OR**
 - Copy of your final 2018 paystub stating your name, address, and itemizing year-to-date 2018 deductions for health care premiums. *Note: These premiums must be paid with after-tax dollars. Reimbursement is not available for premiums paid with pre-tax dollars, through an employer's Section 125 cafeteria plan or other health care plan.*

Note: Health care premiums do not include any co-payments or payments of any coinsurance or deductible amounts required under a health care plan or by a health care provider. Health care premiums also do not include the cost of prescription drug discount cards, premiums paid for hospital or other types of indemnity insurance, or premiums paid for disability insurance.

Qualified Long Term Care Insurance Contract. A “qualified long-term care insurance contract” is defined by Internal Revenue Code Section 7702B(b) as any insurance policy where (A) the policy only covers qualified long term care services, (B) the policy does not cover expenses covered by Medicare as a primary payor, (C) the policy is guaranteed renewable, (D) the policy does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed, except in limited circumstances, (E) all premium refunds and policyholder dividends are, with limited exceptions, applied as a reduction in future premiums or to increase future benefits, and (F) the policy satisfies the consumer protection provisions in Internal Revenue Code Section 7702B(g). Please contact your long term care insurance carrier or broker to determine if your policy qualifies as a “qualified long-term care insurance contract.” Only qualified long term care insurance contact premiums paid for 2018 coverage that you do not claim as a deduction on your 2018 personal income tax return and that do not exceed the 2018 annual limit below are reimbursable under the Plan.

<u>Age on December 31</u>	<u>Annual Limit on Reimbursable Premiums</u>
40 or less	\$420
More than 40 but not more than 50	\$780
More than 50 but not more than 60	\$1,560
More than 60 but not more than 70	\$4,160
More than 70	\$5,200

For reimbursement of premiums paid for coverage under a qualified long term care insurance contract:

- Attach proof of 2018 coverage; **AND**
- Attach copies of proof of premiums paid during 2018 as follows:
 - Copies of cancelled checks for payment of premiums, **OR**
 - Copy of a letter from the insurance provider stating your name, address and the total amount of premiums paid for 2018 coverage, **OR**
 - Copy of the relevant portion of a bank or credit card statement including your name and address confirming the date and amount of the monthly premium payment for 2018 coverage, **OR**
 - Copy of a letter from the insurance provider stating your name and address, advising the premium amount automatically deducted from your bank for 2018 coverage, **OR**
 - Copies of all invoices from your long term care insurer showing payment of 2018 monthly premiums.