KAISER ALUMINUM SALARIED RETIREES VEBA PLAN
QUALIFIED REIMBURSEMENT REQUEST FORM: 2017 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

- **2017 Available Benefit.** The Board of Trustees has set the maximum 2017 benefit for each Family Unit at $4,200.
- **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, 2017 are eligible to receive reimbursement of their 2017 expenses. If you are eligible to participate and need to enroll, please request an Enrollment Form from the Third Party Administrator, Delta Fund Administrators, LLC ("Delta").
- **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 2017 under a health care plan or policy that provides medical, prescription drug, dental, or vision benefits. Effective January 1, 2017, health care premiums include premiums paid for coverage under a "qualified long term care insurance contract." Health care premiums *do not include* any co-payments or payments of any co-insurance 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. Only premiums that you pay on an after-tax basis and that you do not claim as a deduction on your personal income tax return may be submitted for reimbursement under the Plan.
- **Filing Deadline is December 31, 2018.** Claims for the 2017 plan year filed after December 31, 2018 will not be eligible for reimbursement. To ensure this Form is processed properly, be sure to fully complete as well as sign and date this form.
- **Filing Instructions.** Please refer to Attachment A (General Eligibility Information) for further information.

REIMBURSEMENT REQUEST

Name of claimant: _____

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

Check this box if this is: ☐ a new address and/or ☐ a new family unit representative

Please check the appropriate box: This claim is for ☐ Retiree + Spouse ☐ Retiree only ☐ Surviving Spouse ☐ A dependent is included in this claim

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

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

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

Dependent Name (if applicable)*: _____

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

*If necessary, please attach an additional sheet containing name, social security number and date of birth for additional dependents included in this 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

Certification of Marriage

I, _____(name of retiree), am: ❒ currently married ❒ not currently married

If **you are currently married**, please provide the following information:

- My Date of Retirement (MM/DD/YYYY): _____/_____/_____
- Our Date of Marriage (MM/DD/YYYY): _____/_____/_____

Full name of spouse: _____

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 spouse: _____

Please submit copy of death certificate. Name of deceased retiree: _____

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

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

New Family Unit Representative

To change your Family Unit Representative, please complete this section:

Name of Retiree/Surv. Spouse: _____ SSN: _____

Name of New Family Unit Representative: _____

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

Phone: _____ Email (if available): _____

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.

Certification of Surviving Spouse: By signing this Qualified Benefit Reimbursement Request Form, I hereby certify that my date of marriage to the Retiree was _____/_____/_____, and that I have not remarried. As a result of his/her death, I am the Family Unit Representative.

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, and (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, and (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 below.

Signature of Family Unit Representative: _____ Date signed: _____

WAIVER OF MEDICARE COVERAGE

_____ is age 65 or over, but was not enrolled in Medicare Part A during the entire 2017 Plan Year.

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 retired or will retire in the future, 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.

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.
- Or, 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 2017 Social Security Benefit Statement Form 1099-SSA (issued in January 2018 for benefits received during 2017); or
    - Attach a copy of the annual letter from Social Security titled “Your New Benefit Amount”.
- **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 2017 Social Security year-to-date benefits and deductions); or
    - Attach a copy of your 2017 Social Security Benefit Statement Form 1099-SSA (issued in January 2018 for benefits received during 2017).
- **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 2017 health care card; and
    - Attach copies of proof of premiums paid during 2017 as follows:
        - Copies of cancelled checks for payment of premiums,
        - Copy of a letter from the insurance provider stating your name, address and the total amount of premiums paid for 2017 coverage,
        - 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 2017 coverage,

- Copy of a letter from the insurance provider stating your name and address, advising the premium amount automatically deducted from your bank for 2017 coverage,
- Copies of all invoices from your health care plan or insurer showing payment of 2017 monthly premiums, or,
- Copy of your final 2017 paystub stating your name, address, and itemizing year-to-date 2017 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.*

- **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 2017 coverage that you do not claim as a deduction on your 2017 personal income tax return and that do not exceed the 2017 annual limit below are reimbursable under the Plan.

Age on December 31	Annual Limit on Reimbursable Premiums
40 or less	$410
More than 40 but not more than 50	$770
More than 50 but not more than 60	$1,530
More than 60 but not more than 70	$4,090
More than 70	$5,110

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

- Attach proof of 2017 coverage; and
- Attach copies of proof of premiums paid during 2017 as follows:
  - Copies of cancelled checks for payment of premiums,
  - Copy of a letter from the insurance provider stating your name, address and the total amount of premiums paid for 2017 coverage,
  - 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 2017 coverage,
  - Copy of a letter from the insurance provider stating your name and address, advising the premium amount automatically deducted from your bank for 2017 coverage, or
  - Copies of all invoices from your long term care insurer showing payment of 2017 monthly premiums.