MEDICAL EXPENSE REIMBURSEMENT PLAN

OF THE

BURBANK EMPLOYEES RETIREE MEDICAL TRUST

(Including Plan Amendment Nos. 1-14)

Restated Effective August 1, 2019

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PREAMBLE

WHEREAS, the City of Burbank and various groups and bargaining units representing employees of Burbank, which groups are signatory hereto (hereafter, the "Burbank City Employees Coalition" or "Coalition"), entered into an Agreement regarding medical coverage for all City employees, wherein the City and the Coalition agreed that contributions would be made to a benefit trust for the purpose of funding, in whole or in part, retiree health benefits; and

WHEREAS, the City and the Coalition established such a trust as of April 1, 2003, granting administration of the Trust to a Board of Trustees pursuant to the Trust Agreement governing the Burbank Employees Retiree Medical Trust, effective April 1, 2003; and

WHEREAS, the Board of Trustees adopted the Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust, effective April 1, 2003, and thereafter amended the Plan nine times (Plan Amendment Nos. 1-9), incorporating those Amendments into a restated Medical Expense Reimbursement Plan effective March 1, 2014;

WHEREAS, the Board of Trustees has amended the Plan five more times since the restatement (Plan Amendment Nos. 10-14), and now wishes to incorporate those Amendments into a restated Medical Expense Reimbursement Plan;

NOW THEREFORE, the Board of Trustees does herby adopt this restated Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust, including Amendment Nos. 1 through 14, legal updates and scrivener's corrections, restated effective August 1, 2019, as set forth in the following pages.

ARTICLE I
DEFINITIONS

Where the following words and phrases appear in this Plan, they shall have the meaning set forth in this Article, unless the context clearly indicates otherwise. Other words and phrases with special meanings are defined where they first appear unless their meanings are apparent from the context.

1.1 "Active Service" means service as defined in Section 2.2 herein, after the Employee's Effective Date.

1.2 "Association" means a participating labor organization or bargaining unit in the Coalition; and any other labor organization or bargaining unit that has signed a Memorandum of

Understanding with the City, and for which the Trustees have approved participation in the Trust; or any group that is the subject of a special agreement, as defined in the Trust Agreement, with the Trustees.

1.3 "Beneficiary" means an Eligible Retiree, his or her lawful spouse, and the Eligible Retiree's Children; and an Eligible Retiree's Surviving Spouse, and the Eligible Retiree's Surviving Children. A **"Regular Beneficiary"** is a person who has become eligible for monthly benefits by meeting the requirements in Section 2.1(a) hereof. An **"Account Beneficiary"** is a person who has become eligible for benefits from an Employee Account by meeting the requirements in Section 2.1(b) hereof.

1.4 "Board of Trustees" or **"Trustees"** means the duly selected board which administers the Plan and Trust, pursuant to the Trust Agreement.

1.5 "Child(ren)" means a natural child, legally adopted child, or stepchild of the Employee or Eligible Retiree. **"Surviving Child(ren)"** means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Eligible Retiree's death and who continues to meet those requirements. Child or Surviving Child shall also include a child of any age who is legally dependent upon the Eligible Retiree (or was legally dependent upon the Eligible Retiree at the time of the Eligible Retiree's death) for support and maintenance for so long as the child is determined to be totally disabled by the Social Security Administration.

1.6 "City" means the City of Burbank.

1.7 "Coalition" means the Burbank City Employees Coalition, which currently includes the Burbank City Employees Association, AFSCME Local 3143; International Brotherhood of Electrical Workers, Local 18; and the Burbank Management Association.

1.8 "Code" means the Internal Revenue Code, as amended.

1.9 "Contribution" means a mandatory transfer to the Trust from payroll, either for each and every employee in a specific classification within a bargaining unit represented by an Association, pursuant to an MOU, or for every employee in a specific employment classification pursuant to a Special Agreement, as allowed by law. All Contributions must be made without any election on the part of an individual employee (except for contributions made pursuant to continuation requirements of federal law under Code Section 4980B). Any elective contributions (other than under Section 4980B) will be returned within thirty (30) days of discovery that the contribution was made by individual election. A **"Contribution Credit"** or **"CC"** means a credit earned in the Plan for each Contribution of $5 to the Trust on behalf of an Employee for pay periods on or after July 1, 2013.

Historical Note: For Contributions made to the Trust for pay periods before July 1, 2013, an Employee shall receive 520 Contribution Credits for each full year of Contributions, which must include a full Contribution (according to the MOU in effect for that pay period) in each pay period during that year of Active Service. For a year in which the Trust received less than a full year of Contributions on behalf of an Employee, the Trust Office shall prorate the 520

Contribution Credits as follows: 21.67 CCs per pay period occurring in a year with 24 pay periods and 20 CCs per pay period occurring in a year with 26 pay periods.

1.10 "Covered Expense" means any of the following:

(a) Premium or contribution payment on behalf of a Beneficiary to a health, dental or vision insurance plan, for coverage of the Beneficiary in effect while the Beneficiary is eligible for benefits under this Plan, for the type of medical expenses excludible from gross income under Code Section 105(b);

(b) Medical expenses, as defined in Code Section 213(d) (i.e., expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury), including insulin but excluding all other non-prescribed drugs, for medical services provided while the Beneficiary is eligible for benefits under this Plan, and which have not been claimed by the Beneficiary as a deduction on his or her personal tax return; and

(c) Premium payment for qualified long-term care insurance, qualified under Code Sec. 7702B, for coverage of the Beneficiary in effect while the Beneficiary is eligible for benefits under the Plan.

1.11 "Effective Date" means April 1, 2003, for Employees in a bargaining unit represented by the Coalition on that date; or, for other Employees, whatever date contributions for that Employee's Association are required and made to the Trust, if later, as approved by the Trustees.

1.12 "Eligible Retiree" means an Employee who is entitled to benefits under Section 2.1 of the Plan.

1.13 "Employee" means an individual employed as a permanent employee, who is eligible for the City's health coverage; who is a member of a bargaining unit represented by a Coalition member or other Association or who is covered by a Special Agreement (as defined in the Trust Agreement); who is a participant in CalPERS; and on whom the required contributions are made to the Trust Fund pursuant to a Memorandum of Understanding or Special Agreement for all periods of Active Service after the Effective Date.

1.14 "Employee Account" means the individual bookkeeping account maintained by the Trust in the name of a former Employee, which reflects certain contributions made to the Trust as set forth in Section 3.5.

1.15 "Employer" or **"Participating Employer"** means any state, county, or municipality, or any other public agency, public corporation or governmental unit, that contributes to this Plan pursuant to an MOU or Special Agreement, as defined in the Trust Agreement.

1.16 "General Benefit Amount" (or "GBA") means the amount set from time to time by the Trustees as the basic monthly benefit used to calculate each individual Beneficiary's actual monthly Personal Benefit Level. **"Personal Benefit Level"** (or "PBL") means the monthly amount available to a particular Beneficiary for the payment of Covered Expenses.

1.17 "Memorandum of Understanding" or **"MOU"** means a written agreement between the City and an Association that requires contributions to the Trust for retiree medical benefits, and subsequent amendments or successor agreements.

1.18 "Plan" means this separate written document, together with any amendments duly adopted by the Trustees.

1.19 "**QDRO"** or "**Qualified Domestic Relations Order**" means a qualified domestic relations order as defined in ERISA Section 206(d)(3)(B), 29 USC 1056(d)(3)(B).

1.20 "QMCSO" or **"Qualified Medical Child Support Order"** means a qualified medical child support order as defined in ERISA Section 609(a)(2)(A), 29 USC 1169(a)(2)(A).

1.20 "Special Agreement" means a written agreement between an entity and the Trustees and any supplement, amendment, continuation, or renewal thereof that obligates the entity to make contributions to the Trust Fund for employees, for the purpose of providing employee welfare benefits to the employees covered by said agreement, and their beneficiaries. The Contribution under the Special Agreement must be at the same level as that in the MOU of the same employer.

1.20 "Surviving Spouse" means the lawful spouse of an Eligible Retiree who was in that status at least twelve (12) months on the date of the Eligible Retiree's death. The Surviving Spouse of an Employee who has satisfied all the requirements of Section 2.1, except the Employee dies prior to attaining the applicable eligibility age in Section 2.1(a)(2) hereof, shall also be considered a Surviving Spouse.

1.21 "Trust" or **"Trust Fund"** means the Burbank Employees Retiree Medical Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records. **"Trust Office"** means the contract administrator hired by the Board of Trustees to administer day-to-day operations of the Trust.

1.22 "Trust Agreement" or **"Agreement"** means the Trust Agreement governing the Burbank Employees Retiree Medical Trust, effective April 1, 2003, and any amendments hereto.

ARTICLE II
ENTITLEMENT TO BENEFITS

2.1 Eligibility.

(a) Eligibility as a Regular Beneficiary. An Employee shall become an Eligible Retiree entitled to monthly benefits as a Regular Beneficiary under Section 3.2 hereof when he or she meets all the requirements set forth in this Section 2.1(a), as follows:

(1) The Employee has earned five years of Active Service;

(2) The Employee attains age 58; provided however, that if the Employee separates from employment with the City, or another Participating Employer which contributes to the Plan, more than 120 days prior to the date that the Employee satisfies the requirement set forth in subsection 2.1(a)(3) hereof, then the Employee must attain age 65;

(3) The Employee retires from CalPERS, i.e., has applied for and obtained his or her 'official retirement date' from CalPERS and has started receiving monthly pension benefits from CalPERS (other than as a lump sum cash out); and

(4) Contributions have been made to the Plan for all Active Service of the Employee, and Contributions to the Plan on behalf of the Employee have ceased, including COBRA contributions pursuant to Section 2.2(b) or (c).

(b) Eligibility as an Account Beneficiary: Employee Account Benefits. An Employee shall become an Eligible Retiree entitled to receive benefits as an Account Beneficiary under Section 3.5 hereof, when he or she meets all of the requirements set forth in this Section 2.1(b), as follows:

(1) Contributions had been made to the Plan;

(2) The Employee does not meet the Active Service requirement in 2.1(a)(1), and/or the CalPERS retirement requirement in 2.1(a)(3), necessary to become a Regular Beneficiary, and as a result the Employee Contributions (i.e., deductions from wages) made on his or her behalf are credited to an individual Employee Account; and

(3) The Employee has separated from service with a Participating Employer, and Contributions to the Plan on behalf of the Employee have ceased, including COBRA contributions pursuant to Section 2.2(b) or (c).

2.2 Active Service.

(a) Bargaining Unit Service. Active Service is used to determine an Employee's eligibility under this Plan. An Employee may earn Active Service in the following ways:

(1) For regular full-time and regular part-time employment (with a job assignment of 20 hours or more per week) as an Employee;

(2) For time as an Employee on any authorized leave of absence from a participating employer, including authorized disability, illness, or injury, provided that contributions are made to the Plan during that time; and

(3) For service in the Armed Forces, as required by federal law.

(b) Contribution after Termination or Reduction of Employment (COBRA). An Employee whose employment is terminated or whose employment hours are reduced to less than 20 hours per week may continue to earn Active Service and Contribution Credits by periodic self-payment of contributions, for a period of eighteen months or more as required pursuant to the federal law known as COBRA, and rules set by the Trustees.

(c) Spouse or Child Contribution after Death of Employee (COBRA). After the death of an Employee, a Surviving Spouse, or Child may continue to earn Active Service and Contribution Credits by periodic self-payment of Contributions, for a maximum of thirty-six months, pursuant to rules set by the Trustees.

2.3 Self Pay Contributions. Self payment rules for purposes of 2.2(b)-(c) shall be set by the Trustees and may be obtained from the Trust Office.

2.4 No Rebate or Refund. Employees and Beneficiaries shall not be eligible for rebates or refunds of any contributions made; provided, however, that any elective contributions (other than pursuant to the federal COBRA law) will be returned within thirty (30) days of discovery that the contribution was made by individual election.

ARTICLE III
BENEFITS

3.1 General.

(a) Subject to the exclusions and limitations set forth in this Plan, a Beneficiary is entitled to reimbursement of Covered Expenses paid by the Beneficiary on behalf of a Beneficiary, after the Beneficiary becomes eligible under this Plan and after April 1, 2008.

(1) Carryover of Excess Covered Expenses. Amounts of Covered Expenses in excess of the monthly benefit level of the Beneficiary that are properly submitted to the Trust Office shall be paid in subsequent months, up to the Beneficiary's monthly benefit level.

(2) No Carryover of Unused Monthly Benefit Level. If a Beneficiary does not submit a claim for Covered Expenses, paid in a particular month, that is equal to or greater than his or her Benefit Level for that month, then the unused balance of the Beneficiary's monthly Benefit Level for that month shall not be carried over to the next month.

(b) An Employee may become a Beneficiary under Section 2.1(a) or 2.1(b), but not both. The rules in Sections 3.2, 3.3 and 3.4 apply to Regular Beneficiaries, i.e.,

those Beneficiaries who became eligible under Section 2.1(a) hereof. The rules in Section 3.5 apply to Account Beneficiaries, i.e., those Beneficiaries who became eligible under Section 2.1(b) hereof for benefits from Employee Accounts. All benefit payments are subject to proper and timely submission of claims pursuant to Section 3.6 hereof.

(c) Recoupment of Overpaid Benefits. If the Trust overpays benefits in regard to a Beneficiary, the Trust Office shall recoup the overpaid amount from the Beneficiary's future benefit payments or request repayment from the Beneficiary, as directed by the Trustees. The Beneficiary shall be obligated to repay the Trust for overpaid benefits, as allowed by law.

3.2 Personal Benefit Levels for Regular Beneficiaries.

(a) Retirees.

(1) The Trustees shall periodically set the General Benefit Amount, which shall be set forth in Appendix A to the Plan, which is by this reference incorporated herein.

(2) The Personal Benefit Level for an Eligible Retiree shall be determined according to the schedule below, based on the number of Contribution Credits earned by the Eligible Retiree.

Number of Contribution Credits ("CC")	**Percentage of General Benefit Amount**
Tier A: 1,300 CC to 2,599 CC	50%
Tier B: 2,600 CC to 5,199 CC	100%
Tier C: 5,200 CC to 7,799 CC	133%
Tier D: 7,800 CC to 10,399 CC	170%
Tier E: 10,400 or more CC	210%

(3) The General Benefit Amount used to calculate an Eligible Retiree's Personal Benefit Level shall be based on the lower General Benefit Amount in effect on the following: (i) the month in which the Trust ceases to receive contributions on behalf of that Employee; or (ii) the month in which the Eligible Retiree starts to receive benefit payments from the Trust.

(b) Surviving Spouses and Children. The Personal Benefit Level for a Surviving Spouse shall be 100% of the Personal Benefit Level for the Eligible Retiree. If there is no Surviving Spouse and there are surviving Children, the Personal

Benefit Level shall be 50% of the Personal Benefit Level for the Eligible Retiree (to be divided among the Children).

(c) Adjustments. The Trustees may adjust the General Benefit Amount and Tiers from time to time, which adjustments may apply to some or all current and/or future Beneficiaries, as determined by the Trustees.

3.3 Commencement of Benefits for Regular Beneficiaries.

(a) Retiree. An Eligible Retiree who is a Regular Beneficiary shall be eligible for monthly benefits upon meeting the eligibility requirements of Section 2.1(a) and cessation of Contributions on his or her behalf, including COBRA contributions. Benefit payments shall commence upon either expiration of the COBRA election period, or if the Beneficiary elects to make COBRA contributions, benefit payments shall commence on termination of COBRA contributions, pursuant to Section 2.2(b) and federal COBRA law.

(b) Surviving Spouse. A Surviving Spouse shall be entitled to monthly benefit payments starting the month after the Eligible Retiree would have attained the applicable eligibility age in subsection 2.1(a)(2) hereof, or on termination of COBRA contributions, whichever occurs later.

(c) Surviving Children. If there is no Surviving Spouse, benefit payments to a Surviving Child shall commence upon death of the Eligible Retiree, or on termination of COBRA contributions, whichever occurs later.

3.4 Termination of Benefits for Regular Beneficiaries.

(a) Eligible Retirees. An Eligible Retiree's monthly benefit coverage under the Plan shall terminate on the date of the Retiree's death. Claims for Covered Expenses which are properly and timely submitted on behalf of the deceased Retiree after death, will be paid for the months through and including the month in which the Retiree died, at the rate of the monthly Personal Benefit Level for that Retiree. If the Regular Beneficiary returns to employment with a Participating Employer, then benefit payments shall be suspended; provided, however, that upon subsequent cessation of all employment with a Participating Employer, benefit payments shall resume.

(b) Surviving Spouse and Children. The coverage of a Surviving Spouse under the Plan shall terminate on the first to occur of the following:

(1) The date of the Surviving Spouse's death. Claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Surviving Spouse after death, will be paid for the months through and including the month in which the Surviving Spouse died, at the rate of the monthly Personal Benefit Level for that Surviving Spouse.

(2) If there is no Surviving Spouse, Children shall be entitled to the benefits until loss of Child status, as defined in Section 1.5 hereof, or death.

(c) Benefit coverage may be modified or terminated pursuant to Article VI hereof, and such changes may apply to some or all current and/or future Beneficiaries.

3.5 Benefits from Employee Accounts for Account Beneficiaries.

(a) Employee Account. An Employee who becomes an Eligible Retiree under Section 2.1(b) hereof as an Account Beneficiary, and his or her Beneficiaries, are entitled to reimbursement of Covered Expenses from his or her Employee Account. The balance in the Employee Account shall include the following amounts:

(1) *Employee Contributions.* For an Employee who does not satisfy the eligibility requirements of Section 2.1(a)(1) and/or 2.1(a)(3), the Trust Office shall calculate all Employee Contributions, i.e., deductions from wages, made to the Plan by the Employee and credit those Contributions to the Employee Account, according to rules set by the Board of Trustees.

(2) *Earnings.* The Trust Office shall periodically credit interest earned on the Employee Account balance after credit of Employee contributions to the Employee Account, at the current rate of the money market account selected by the Trustees, to the Employee Account balance.

(3) *Debits.* The Trust Office shall periodically debit from the Employee Account an amount of the Plan's administrative expenses proportionate to the cost for administration of the Employee Account, as determined by the Trustees.

(b) No Personal Benefit Level from Employee Account. There shall be no maximum amount (i.e., no Personal Benefit Level) on a claim against the Employee Account, so long as all claims are for reimbursement of Covered Expenses, and the balance in the Employee Account is sufficient to reimburse the claim.

(c) Commencement and Termination of Benefits from Employee Accounts. An Account Beneficiary shall be eligible for reimbursement of Covered Expenses from the Employee Account upon separation from employment with a Participating Employer and cessation of Contributions on his or her behalf, including COBRA contributions. Benefit payments from the Employee Account shall commence upon either expiration of the COBRA election period, or if the Beneficiary elects to make COBRA contributions, then termination of COBRA contributions, pursuant to Section 2.2(b) and federal COBRA law. Benefits from the Employee Account will terminate when the Employee Account balance reaches zero. If the Account Beneficiary returns to employment with a

Participating Employer, eligibility for this benefit shall be suspended until termination of such employment.

(d) Survivor Benefits from Employee Account. The Surviving Spouse of an Eligible Retiree is entitled to reimbursement benefits of Covered Expenses until the Employee Account balance reaches zero. If there is no Surviving Spouse, the Surviving Child(ren) of the deceased Eligible Retiree shall be entitled to such benefits until the Employee Account balance reaches zero or the Child no longer meets the definition of Child under Section 1.5 hereof.

(e) Forfeitures.

(1) *Death of Beneficiaries.* Any balance left in the Employee Account upon the death of all Beneficiaries will forfeit to the Plan.

(2) *Employer Contributions.* If the Employee does not satisfy the eligibility requirements of Section 2.1(a)(1) and/or 2.1(a)(3), then any Employer contributions made to the Plan on behalf of an Employee shall not be credited to the Employee Account and shall forfeit to the Plan.

(f) Modification of Rules. The Trustees may modify or amend the rules for benefit payments from Employee Accounts, which may apply to some or all current and/or future Beneficiaries.

3.6 Benefit Claim Procedure.

(a) To make a claim for Plan benefits, Beneficiaries must present independent third-party documentation of the following:

(1) the date that medical services were provided or medical supplies purchased (which date must be prior to submission of the claim), or the dates of coverage for insurance premium;

(2) the medical expenses, as defined in Section 1.10(b) hereof, or insurance premiums, as defined in Section 1.10(a) or (c) hereof; and

(3) the Beneficiary's payment of the Covered Expense.

Along with the above documentation, Beneficiaries must submit a completed claim form, approved by the Trustees, to the Trust Office. Prior to issuing payment, the Trust Office shall review such documentation and claim form and determine whether to grant or deny coverage under the Plan. Documentation must be submitted for each claim, except that documentation of a recurring Covered Expense, under Section 1.10(a) or (c), must be submitted upon request, but no less frequently than annually.

(b) If the Trust Office grants coverage on the Beneficiary's claim, all Plan benefits are personal to the Beneficiary and payable only to the Beneficiary, except as provided in subsection 3.6(g), regarding Beneficiary deemed to be incompetent. If the Trust Office denies coverage, in whole or part, on the Beneficiary's claim or the Plan takes other action adverse to the Beneficiary, the Beneficiary may appeal the denial of coverage or any other adverse determination of the Plan, by taking action pursuant to Section 4.3 hereof.

(c) Documentation of payment under subsection 3.6(a)(3) above shall include, but not be limited to, the following, subject to Trust Office verification, as determined by the Trustees in their sole discretion:

(1) Canceled check drawn to the name of the insurance provider or medical services provider;

(2) Copy of confirmation of electronic payment to the insurance provider or medical services provider; or

(3) Receipt for payment from the medical insurance provider or medical service provider.

Along with the above documentation, Beneficiaries must submit a completed claim form, approved by the Trustees, to the Trust Office. Prior to issuing payment, the Trust Office shall review such documentation and claim form and determine whether to grant or deny coverage under the Plan. Documentation must be submitted for each claim, except that documentation of a recurring Covered Expense, under Section 1.10(a) or (c), must be submitted upon request, but no less frequently than annually.

(d) Beneficiaries may submit claims for reimbursement of Covered Expenses, in the order described below:

(1) Eligible Retiree. Subject to Subsection (4) below, only an Eligible Retiree may submit claims for reimbursement of Covered Expenses of a Beneficiary in his or her family.

(2) Surviving Spouse. Subject to Subsection (4) below, after the death of the Eligible Retiree, only a Surviving Spouse may submit claims for reimbursement of Covered Expenses of a Beneficiary in his or her family, except that during the period that the Surviving Spouse is not eligible for monthly benefit payments as a Regular Beneficiary under Section 3.3(b) hereof, the Surviving Child may submit his or her own claims for reimbursement as a Regular Beneficiary.

(3) Surviving Children. If there is no Surviving Spouse or the Surviving Spouse is not currently eligible for monthly benefit payments, a Surviving

Child may submit claims for reimbursement of his or her own Covered Expenses from the monthly benefit amount as a Regular Beneficiary. If there is no Surviving Spouse, a Surviving Child may submit claims for reimbursement of his or her own Covered Expenses from the individual account balance as an Account Beneficiary.

(4) Delegation of Authority to Submit Claims. An Eligible Retiree or Surviving Spouse may delegate authority to submit claims to a family member by completing and submitting to the Trust Office a form approved by the Trustees for that purpose.

(5) Revocation of Authority to Submit Claims. An Eligible Retiree or Surviving Spouse may revoke authority granted pursuant to Subsection 3.6(d)(4) hereof at any time by submitting a written revocation (including via email) to the Trust Office.

(e) Claims for Plan benefits must be submitted no later than ninety (90) calendar days from the date on which the Beneficiary incurred the Covered Expense. However, the Trust Office may waive the deadline for good cause shown, pursuant to guidelines established by the Trustees. For purposes of this paragraph, a Covered Expense is "incurred" when the Beneficiary pays it, not when the Beneficiary receives a bill for the medical service or insurance.

(f) Subject to subsection (g), below, unless specifically provided by law, the Trustees shall not make any payments on behalf of or distributions to any person entitled to any benefits except to a Beneficiary personally or pursuant to a QDRO or QMCSO under federal law.

(g) If a Beneficiary is deemed to be incompetent by a lawful judicial forum, then the Trust Office may pay any benefit claims payment to the person that the judicial forum has appointed as the Beneficiary's representative, and the Beneficiary's representative may submit claims and take action on the Beneficiary's behalf, subject to the requirements of this Section 3.6. The Trustees shall not be under any duty to oversee the application of funds so paid, and receipt by the Beneficiary's representative shall be full acquittance to the Trustees, the Trust Office, and the Plan.

(h) A Beneficiary or Employee who does not have a claim for current Covered Expenses, but seeks to enforce his or her rights under the terms of the Plan or seeks to clarify his or her rights to future benefits or eligibility under the terms of the Plan, may submit a written request to the Trust Office explaining his or her position and asking for a decision or clarification. The Beneficiary or Employee should enclose any relevant documentation supporting the request. If the Beneficiary or Employee is not satisfied with the decision of the Trust Office, the Beneficiary or Employee may request an appeal of the Trust Office decision to the Board of Trustees pursuant to Section 4.3 hereof.

3.7 Prohibition of Assignment and Protection from Creditors

(a) No Assignment or Encumbrance of Benefits. No benefit payment under this Plan shall be subject in any way to assignment, alienation, sale, transfer, pledge, attachment, garnishment, or encumbrance of any kind. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish, or encumber the benefits or monies due from this Plan, whether for current or future benefits, shall be void. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any right or interest under this Plan for part or all of the Employee's or Beneficiary's current or future benefit payments. Any such arrangement shall be void under this Plan.

(b) No Assignment of Rights under Law. Any attempt by the Employee or Beneficiary, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish or encumber the Employee's or Beneficiary's rights under this Plan shall be void, including, but not limited to, the right to bring any action in court, file a lawsuit or appeal a coverage determination, the right to enforce rights or eligibility under the Plan, the right to benefits or eligibility under the Plan, the right to clarify rights to future benefits or eligibility under the Plan, and the right to request copies of Plan documents or annual reports. The Plan shall not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives from an Employee or Beneficiary any such right. Any such arrangement shall be void under this Plan.

(c) Protection of Benefits from Creditors. The Plan and Fund are exempt from all claims from creditors or other claimants and from all orders, decrees, garnishments, executions, and legal processes or proceedings, except in connection with qualified medical child support orders or qualified domestic relations orders.

ARTICLE IV
CLAIM APPEAL PROCEDURES

4.1 Beneficiary's Duty to Notify Trust Office of Claim. The Beneficiary is required to notify the Trust Office of his or her claim for benefits pursuant to Article III hereof, before he or she is entitled to either receive benefits under this Plan, or appeal the Trust Office's decision denying a request for benefits.

4.2 Acceptance or Denial of Claims by the Trust Office.

(a) Standard Claim Decision - Timing. The Trust Office shall consider each claim for Plan benefits and determine whether to grant or deny coverage under the Plan. Subject to Sections 4.2(b) and 4.2(c) hereof, the Trust Office shall send written

notification of its decision to the Beneficiary not later than 30 calendar days after receipt of the Beneficiary's claim. If coverage is granted, the Beneficiary shall receive payment as stated in Section 3.6(b) hereof. If the claim is denied, the Beneficiary has the right to appeal the claim, pursuant to Section 4.3 hereof and the Plan's "Appeal Procedures," if any, available from the Trust Office.

The denial notification shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request; and

(5) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits and a statement of the Beneficiary's right to bring an action under ERISA Section 502(a), after exhaustion of administrative procedures.

(b) Extension of Time - Special Circumstances. If the Trustees determine that special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the Beneficiary prior to the termination of the initial 30 calendar day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trustees expect to render a benefit determination. In no event shall such extension exceed a period of 15 calendar days from the end of the initial period (45 calendar day total).

(c) Extension of Time – Failure to Submit Information. The period of time for the Trustees to make a benefit determination may be extended if the Beneficiary fails to submit all necessary information to allow the Trustees to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Beneficiary until the date the Beneficiary provides to the Trust Office the requested information. The Beneficiary shall be allowed at least 45 calendar days from receipt of the request for additional information within which to provide the information.

4.3 Appeal Procedures. The Trustees, Beneficiaries and any person who claims to be entitled to benefits under this Plan shall follow the provisions in this Article IV.

(a) Exclusive Procedures. The procedures specified in this Section, together with any written hearing procedures adopted by the Trustees, shall be the exclusive procedures available to a person dissatisfied with an eligibility determination, benefit claim decision or response to written request pursuant to Section 3.6(h) hereof, or to a person who is otherwise adversely affected by any action of the Trustees.

(b) Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in writing within 181 calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Beneficiary believes that the grounds for denial of benefits are inapplicable. The Beneficiary may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for benefits to the Trustees. The Beneficiary shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Beneficiary's claim for benefits.

(c) Hearing Procedure. If the Beneficiary requests a hearing, the Board of Trustees shall conduct a hearing, as required by applicable law. The Beneficiary shall be entitled to present his or her position and any evidence in support thereof at the hearing. The Beneficiary may be represented by an attorney or any other representative of his or her choosing at the Beneficiary's expense.

(d) Decision on Appeal. On the appeal, the Trustees shall issue a written decision, affirming, modifying or setting aside the former decision. Any notification of a denial of benefits shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) A statement that the Beneficiary is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Beneficiary's claim for benefits; and

(4) An explanation of the Beneficiary's right to bring an action in federal court under ERISA Section 502(a), after exhaustion of the Plan's administrative procedures;

(5) A statement identifying any internal rules, guidelines, protocols, or other similar criteria relied upon in the denial, copies of which will be provided free of charge to the Beneficiary upon request; and

(6) The statement, "You and your beneficiaries may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact his or her local U.S. Department of Labor Office and your State insurance regulatory agency."

4.4 Right to Court Review, Time Limit to Bring Lawsuit

(a) General. Upon exhaustion of these procedures in this Article IV, a Beneficiary, who is dissatisfied with an eligibility determination, benefit award or response to written request pursuant to Section 3.6(h) hereof may bring an action in federal court pursuant to ERISA Section 502(a).

(b) Limitation Period for Filing a Lawsuit Against the Trust for Benefit Payments. A Beneficiary has the right to bring action as described in Section 4.4(a) hereof in federal court, pursuant to ERISA Section 502(a), no later than one year after the exhaustion of administrative remedies, which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim, or other complaint described in Section 3.6(h).

ARTICLE V
MISCELLANEOUS

5.1 Limitation of Rights. Neither the establishment of the Plan and the Trust, nor any modifications thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving any Beneficiary or other person any legal or equitable right of action, or any recourse against any Association, the Coalition, or its employees, the Trust or its employees, the Trust Office or the Trustees, except as provided in this Plan and the Trust Agreement.

5.2 Applicable Laws and Regulations. Reference in this Plan to any particular sections of any local, state or federal statute shall include any regulation pertinent to such sections and any subsequent amendments to such sections or regulations. Except where this Plan is subject to California law, this Plan and the Fund shall be guided by ERISA, 29 U.S.C. 1001, et seq.

5.3 Confidentiality. It is agreed and understood that each Beneficiary who applies for benefits under this Plan is entitled to the same rights and consideration, including the right of confidentiality, and the Trustees shall not be required to nor shall they reveal to any other persons, including the Coalition, its officers, agents or employees, any matters revealed to them in confidence by such Beneficiary in the course of his or her application for benefits, except to the extent required by law. This Plan is subject to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which imposes specific restrictions on the use and disclosure of protected health information.

5.4 Trustee Authority. The Trustees shall have the authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of this Trust and Plan, or of the

benefit plans, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision shall be binding and conclusive.

5.5 Divorce and Court Orders: QDRO and QMCSO Review Costs. The Trust reserves the right to deduct the reasonable costs associated with reviewing and implementing a QDRO or QMCSO, or an order proposed as such, from the benefits payable to the Eligible Retiree or Beneficiary, according to rules set by the Trustees.

ARTICLE VI
AMENDMENTS AND TERMINATION

In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources and applicable law, a program dedicated to providing the maximum possible benefits for all Beneficiaries, the Trustees expressly reserve the right, in their sole discretion, at any time and from time to time, provided that such action does not violate federal discrimination law:

(a) To adjust the General Benefit Amount.

(b) To amend or rescind any provision of this Plan.

(c) To terminate the Plan.

Any such changes may apply to some or all, current and/or future Beneficiaries.

Amendments shall be made by action of the Board of Trustees pursuant to Article IV of the Trust Agreement.

Adopted at a Board of Trustees meeting on the 6th day of August 2019, and restated effective August 1, 2019.

For the **BOARD OF TRUSTEES,**
BURBANK EMPLOYEES RETIREE MEDICAL TRUST

_____
Trustee

_____
Trustee

APPENDIX A
to the
MEDICAL EXPENSE REIMBURSEMENT PLAN
of the
BURBANK EMPLOYEES RETIREE MEDICAL TRUST

Operative Date*	General Benefit Amount
January 1, 2012	$300

** Note that the Personal Benefit Level for an Eligible Retiree shall be set according to the lesser of the General Benefit Amount in effect during: (1) the month in which the Trust ceases to receive Contributions on behalf of that Employee; or (2) the month in which the Eligible Retiree starts to receive benefit payments from the Trust. Personal Benefit Levels for Eligible Retirees shall vary and be determined pursuant to the schedule under Plan Section 3.2.*