SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL EXPENSE REIMBURSEMENT PLAN OF THE BURBANK EMPLOYEES RETIREE MEDICAL TRUST

Including COBRA General Notice
And
HIPAA Privacy Notice

Issued: August 2024
Based on Plan restated effective August 1, 2024
(Dr. 5/21/24, Incl. Plan Am. Nos. 1-19)

SUMMARY PLAN DESCRIPTION

Medical Expense Reimbursement Plan of the
BURBANK EMPLOYEES RETIREE MEDICAL TRUST
August 2024

HIGHLIGHTS OF THE PLAN

- **ELIGIBILITY**. Generally, current employees will need 5 years of participation in the Trust to achieve eligibility for benefits.

- **BENEFITS**. Your benefits from this Trust come in the form of monthly reimbursement for certain medical costs, which are called "Covered Expenses,"[1] incurred after you retire. Your Personal Benefit Level is calculated as a percentage of the General Benefit Amount and may be more or less than the General Benefit Amount, depending on the number of Contribution Credits that you have earned from contributions to the Trust. See Q&A No. 2.2 herein for the benefit level schedule. Also, you may contact the Trust Office to find out your current monthly benefit level.

- **CLAIMS**. You must present your claims to the Trust Office with your proof of payment for Covered Expenses, on a form approved by the Trustees, no later than 3 months after the end of the calendar year in which the Beneficiary paid the Covered Expense, i.e., by March 31st.

- **CHANGE OF EMPLOYMENT STATUS, ADDRESS, OR FAMILY COMPOSITION**. Please notify the Trust Office of changes to your employment status or any significant life event that you think might affect your participation in the Trust. For example, if you retire or otherwise separate from employment, you might be entitled to begin receiving benefits, or to make self-pay contributions under COBRA; or if there is a change in mailing address or family composition (e.g., marriage, divorce, or birth of a child), failure to notify the Trust Office may result in loss or delay of benefit payments.

- **TRUST OFFICE**. The Trust Office provides important services to plan participants. For example, to find out your Personal Benefit Level, submit any benefit claims, request a copy of the Plan or notify the Trust of a change in address, you should contact the Trust Office. You can contact the Trust Office at:

Burbank Employees Retiree Medical Trust
c/o Benefit Programs Administration ("BPA")
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-mail: burbankcity@bpabenefits.com
Phone: (213) 406-2350
Toll Free Phone: (888) 806-8944
www.bermt.com

NOTE: The questions and answers in this Summary Plan Description ("SPD") have been designed to provide you with key information about the Burbank Employees Retiree Medical Trust, but do not provide all the details and limitations of the Plan. Exact specifications are provided in the "Restated Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust," restated effective August 1, 2024, and as amended thereafter. If there is a conflict between what is contained in the Plan and what is contained in this SPD or any other descriptions, the terms of the Plan will prevail. Note that the capitalized terms contained herein are defined in the formal Plan document.

[1] See Q&A No. 1.3 below for a detailed description of the type of expenses for which you may be reimbursed.

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August 2024

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BURBANK EMPLOYEES RETIREE MEDICAL TRUST
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PART 1
GENERAL DESCRIPTION OF PLAN PARTICIPATION AND BENEFITS

1.1 Who can participate in the Burbank Employees Retiree Medical Trust?

Eligibility in the Trust is generally open to all regular full-time employees of the City of Burbank, and regular part-time employees with a job assignment of 20 hours or more per week, who: (1) are eligible for the City's health coverage; (2) participate in CalPERS; and (3) have Contributions made to the Trust on their behalf, as required by the applicable MOU between an Association in the Coalition (BCEA, IBEW or BMA)[2] and the City (or required by a Special Agreement for employees not represented by an Association).

1.2 What type of benefit does the Trust provide?

After meeting the eligibility requirements, Eligible Retirees are entitled to a monthly reimbursement benefit towards the payment of Covered Expenses, i.e., health insurance premiums and tax deductible medical expenses paid by an Eligible Retiree or Beneficiary of the Eligible Retiree. Beneficiaries include the Spouse and Children of the Eligible Retiree and the Eligible Retiree's Surviving Spouse and Children. See Q&A 5.2 below for a definition of Spouse and Child. Reimbursement benefit payments are subject to proper and timely submission of benefit claims to the Trust Office. The amount of the reimbursement benefit payment is limited to the Beneficiary's Personal Benefit Level. See Q&A 2.2 below.

Cost Sharing. It is important to note that the Plan reimburses toward the cost of Covered Expenses, but your Personal Benefit Level may not cover the entire cost of your Covered Expenses. If your Personal Benefit Level does not cover their entire cost, you will be responsible for the balance of any Covered Expense amounts you owe in excess of your Personal Benefit Level.

1.3 What type of medical expenses will be reimbursed by the Trust?

The following medical expenses are considered "Covered Expenses," and will be reimbursed by the Trust:

- Premium or contribution payments for coverage under health, dental, or vision insurance plans.

- Medical expenses excludable from gross income under Internal Revenue Code Section 213(d), i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs. For a complete list, see IRS Publication 502, which can be found at **www.irs.gov/pub/irs-pdf/p502.pdf**

[2] Associations participating in the Coalition are: Burbank City Employees Association AFSCME Local 3143; International Brotherhood of Electrical Workers Local 18; and Burbank Management Association.

- The tax-deductible portion of premium payments for qualified long-term care (LTC) insurance. LTC insurance is qualified if it insures only long-term care, is guaranteed renewable, does not provide a cash surrender value, does not provide reimbursement for Medicare expenses, and does not distribute premium refunds or similar payments to the policyholder (except generally upon the death of the insured).

  See Plan Section 1.10 for a full definition of Covered Expenses.

1.4 What type of premium payments are not eligible for reimbursement through the Plan?

- Premiums paid with pre-tax income are not eligible for reimbursement through the Plan. When a payment is "pre-tax," it means that the premium was paid with income that is not taxable to you. For example, suppose the money used to pay the premium was deducted from your or your spouse's salary or wages before taxes were calculated. In that case, that amount will not be considered taxable income on your or your spouse's personal income tax return. The IRS has taken the position that you have already received a tax break when pre-tax monies were used to pay the premiums. Therefore, reimbursements of premiums paid with pre-tax income could lead to an impermissible double-tax (free) benefit under IRS regulations.

- The prohibition against reimbursement applies only to premiums deducted pre-tax from salary or wages or deducted on your personal income tax. Premiums that were paid with post-tax dollars can still be submitted for reimbursement.

- Please note that the Trust Office will issue claim denials if premium documentation indicates that the insurance premium was paid "pre-tax" or "tax deferred."

1.5 Who is responsible for determining whether pre-tax income was used to pay for premiums?

- You are responsible for determining whether you have paid your premium with pre-tax dollars. Please work with your tax professional to determine any tax implications.

- If you submit a claim for premiums paid with pre-tax dollars and the Trust Office pays the claim, the Trust has the right to recoup that overpayment from you, including any tax penalties, interest and costs incurred, when the Trust Office discovers that the premium was not reimbursable.

1.6 Does the Healthcare Enhancement for Local Public Safety Officers (HELPS) Act affect my premium reimbursements?

- The Plan does not provide reimbursements for any premiums deducted from taxable income on an Eligible Retiree's personal income tax return. This includes premiums deducted from taxable income by public safety retirees pursuant to the Healthcare Enhancement for Local Public Safety Officers (HELPS) Act. The HELPS Act permits public safety retirees to deduct $3,000 of their pension income used to pay their healthcare insurance premiums as non-taxable income on their personal income tax return.

PART 2
ELIGIBILITY AND MONTHLY BENEFITS

2.1 Who is eligible for benefits?

An Employee described in Q&A No. 1 becomes an Eligible Retiree entitled to monthly benefits under the Plan, generally, after the Employee meets the following requirements:

- Earns five (5) years* of Active Service in the Trust (i.e., five years of contributions to the Trust).

- Contributions are made to the Trust for all years of Active Service.

- 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). Return to any employment with the City of Burbank after retirement will cause a suspension of benefit payments for the length of that re-employment. Benefit payments will resume upon separation from all employment with the City of Burbank.[3]

- Attains age 58, as long as the Employee retires from CalPERS (as defined above) within 120 days from separating employment with the City of Burbank or another Participating Employer. If the Employee retires from CalPERS more than 120 days after separating from employment with a Participating Employer, then he or she must attain age 65 for eligibility.

Note that an Employee who separates from employment prior to earning five (5) years of Active Service has an Employee Account benefit from the Plan. See Part 3 below.

****Note: A former Employee who cashes-out his or her CalPERS retirement benefits for a lump sum payment is not considered "retired from CalPERS" under the Plan. A former employee, who does not "retire from CalPERS" as defined in Plan Section 2.1(a)(3), is <u>not</u>***

[3] This suspension of benefits applies to employment with any BERMT Participating Employer, but does not apply if the Eligible Retiree is employed by an entity that is not a Participating Employer.

eligible as a Regular Beneficiary for monthly benefit payments. Instead, these former employees are Account Beneficiaries eligible for an Employee Account benefit. See Part 3 below.

2.2 What is the General Benefit Amount? And what is my Personal Benefit Level?

The General Benefit Amount is a basic monthly benefit set periodically by the Trustees and used as part of a formula (see below) to calculate each individual Beneficiary's actual monthly Personal Benefit Level. The current General Benefit Amount is $300, effective January 1, 2012.

The Personal Benefit Level is the maximum monthly amount available to an Eligible Retiree for the reimbursement of Covered Expenses; it is set according to the schedule below as a percentage of the General Benefit Amount. An Eligible Retiree's Tier for calculation of the Personal Benefit Level depends upon the number of Contribution Credits (or "CCs") earned through payroll contributions during employment. An Employee earns one Contribution Credit for each $5 contributed to the Plan after August 1, 2013, and 20 Contribution Credits for each pay period in which the Trust received a full contribution (as required by the Employee's MOU) prior to August 1, 2013.[4]

Number of Contribution Credits (CC)	Percentage of General Benefit Amount	Personal Benefit Level Based on General Benefit Amount of $300
Tier A: 1,300 CC to 2,599 CC	50%	$150
Tier B: 2,600 CC to 5,199 CC	100%	$300
Tier C: 5,200 CC to 7,799 CC	133%	$400
Tier D: 7,800 CC to 10,399 CC	170%	$510
Tier E: 10,400 or more CC	210%	$630

The Personal Benefit Level for an Eligible Retiree is based upon the lesser of the 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.

2.3 Is it possible for my Personal Benefit Level to change?

Yes, it is possible for your Personal Benefit Level to change, i.e., benefits and benefit levels under the plan are <u>not</u> vested. It is the goal of the Trustees to keep benefit levels steady. However, the Trustees reserve the right and power to adjust the General Benefit Amount(s),

[4] For years prior to August 1, 2013, with 24 pay periods, an Employee earns 21.67 CCs per pay period.

the percentages set forth in Q&A No. 2.2 above, or other Plan terms. Such adjustments, or termination of benefits, may apply to some or all current as well as future Beneficiaries.

Note that in the event the Trust Office overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments until the Trust has recouped the overpaid amount, or the Trust may seek repayment of the overpaid amount from you directly to the Trust. This may result in a temporary change in your benefit level until the overpayment is fully recouped.

2.4 When do my benefit payments start?

Your eligibility for benefits begins when you attain the eligibility requirements and contributions to the Plan on your behalf have stopped. However, your actual benefit payments may not start until a couple months later, as the Trust Office needs to get notice from the City of your last contributions and you need to provide proof of your CalPERS retirement.

You may want to make COBRA payments following separation from employment if monthly COBRA payments will help you to attain the next Tier of Personal Benefit Level (see Q&A 2.2 above) or to attain the minimum years of Active Service (5 years of contributions) for eligibility for the monthly benefit. If you have not attained 5 years of Active Service, your benefit payments will not start until the COBRA election period (60 days) has passed and you have decided whether to elect to self-pay COBRA contributions. If you decide to make COBRA contributions to attain the 5-year Active Service eligibility requirement, your monthly benefit payments will not start until your COBRA contributions to the Plan have stopped and your eligibility will start on that date, i.e., you can only be reimbursed for Covered Expenses paid after your eligibility date.

If you have already attained the minimum 5 years of Active Service for eligibility, but you elect to make COBRA contributions to attain the next Personal Benefit Level tier, your benefit payments will start at your current Personal Benefit Level during your COBRA contributions and your Personal Benefit Level will increase when you have made sufficient COBRA contributions to attain the next Personal Benefit Level tier. You must make COBRA contributions on time each month in order to continue making monthly COBRA contributions; if you are late with a monthly payment (beyond the 30-day grace period), your right to make COBRA contributions is terminated and you may not attain the next Personal Benefit Level. COBRA contributions are not refunded if you do not attain the next Personal Benefit Level tier. The COBRA General Notice (enclosed) provides additional information about your rights and responsibilities.

2.5 What happens if I don't use my full monthly Benefit Level each month?

The Trust Office will <u>not</u> carryover any unused balance of a Beneficiary's monthly Benefit Level to the next month. For example, if a Beneficiary with a monthly Benefit Level of $300 submits a claim for a Covered Expense of $200 paid in May, the Trust Office will pay the beneficiary $200 and the remaining $100 will not carryover to June, i.e, the June Benefit Level is still $300. To use the $100 balance of the Benefit Level from May, the Beneficiary

must submit a claim for another Covered Expense paid in May. The claim for that Covered Expense must be submitted to the Trust Office prior to the claims deadline, which is 90 days after payment of the Covered Expense. So, for a payment made on June 12, 2018, the claim must be submitted no later than September 10, 2018.

2.6 What happens if I have a high monthly claim in one month? Can I get the excess Covered Expenses paid in a later month?

Yes. If you paid for Covered Expenses that exceed your monthly Benefit Level, the Trust Office will reimburse you for those excess expenses in a subsequent month when you have not submitted claims sufficient to use all of your monthly Benefit Level. For example, if your monthly Benefit Level is $300 and you submit a claim for a Covered Expense of $400, then you would receive payment for that claim at $300 in the first month and $100 in the next month. If you submit claims of $400 in the first month, $300 in the second month, and no claims in the third month, then you will receive reimbursement for the excess $100 in the third month. The excess Covered Expense is carried over and reimbursed in a month when you have not submitted claims equal to your monthly Benefit Level.

PART 3
EMPLOYEE ACCOUNT BENEFITS

3.1 How do I become eligible for Employee Account benefits?

An Employee who separates from service with a Participating Employer, on or after January 1, 2008, without meeting the minimum Active Service requirement of five years for monthly benefits, becomes an Account Beneficiary instead of a Regular Beneficiary. Also, an Employee who cashes out his/her CalPERS retirement benefits for a lump sum, becomes an Account Beneficiary instead of a Regular Beneficiary.

3.2 What are Employee Account benefits?

Account Beneficiaries are entitled to reimbursement of Covered Expenses in an amount limited to the balance of their Employee Account. Unlike the monthly benefit described in Part 2 of this Summary, there is no monthly limit on Employee Account benefits, i.e., as long as the Employee Account has a sufficient balance. All claims must be for reimbursement of Covered Expenses and properly and timely submitted. Eligibility for benefits will commence following separation from employment and continue until the Employee Account balance reaches zero.

3.3 What is included in the balance of my Employee Account?

The balance of an Employee Account will include the following:

- The total amount of employee contributions (i.e., contributions deducted from wages) made to the Plan on behalf of the employee;

- Interest earnings, at the current money market rate, on the Employee Account balance after credit of Contributions to the Employee Account; and

- ❖ Deduction for a proportionate share of administrative expenses.

NOTE: Forfeiture of Employer Contributions. If an Employee ceases employment without earning five (5) years of Active Service or takes a lump sum cash out of his/her CalPERS retirement benefits, the employer Contributions made on behalf of the Employee to the Plan will be forfeited.

PART 4
LOSS, DENIAL, OR DELAY OF BENEFITS

4.1 What are the circumstances that may result in ineligibility or denial of benefits; or amendment or termination of the Plan?

Circumstances that may result in disqualification, ineligibility, denial, or the loss of benefits include: failure by the Employee or employer to make required contributions; failure to properly submit claims; expense receipts or proper claims documentation; missing the claims deadline; failure to meet the eligibility requirements; death; or termination of the Plan. Also, note the following events will cause termination of benefits:

- ❖ An Eligible Retiree's benefits under this Plan will terminate upon his/her death. An Eligible Retiree's benefits under this Plan will be suspended upon return to employment with the City of Burbank or another Participating Employer; provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with the City and other Participating Employers.

- ❖ A Surviving Spouse's benefits under this Plan will terminate upon his/her death.

- ❖ A Surviving Child's benefits under this Plan will terminate upon death of the Child or the loss of Child status under the Plan.

Benefit coverage and benefit levels may be modified or terminated pursuant to Section VI of the Plan and such changes may apply to some or all current and/or future Beneficiaries. In the event of the termination of the Plan, assets of the Plan which remain after payment of expenses associated with termination will be allocated and distributed to the Beneficiaries in accordance with Section 501I(9) of the Internal Revenue Code.

4.2 What type of information may affect my benefits, so I should update the Trust Office?

It is important for the Trust Office to have an up-to-date record of information that might affect the benefits and rights of Employees and Beneficiaries of the Trust, e.g., employment status, mailing address, identity of spouse and children, etc. The Trust Office relies on such information to administer the Trust, for example, to send benefit payments to Beneficiaries and other applicable notices related to the Plan.

Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan. Please update the Trust Office with any changes you experience that might affect your benefits or rights from the Trust, including but not limited to, the following changes:

- Mailing address, personal email address, and phone number (including mobile number)
- Employment status (e.g., retirement, lay-off, separation from employment, or reduction in hours)
- Spouse (e.g., divorce or marriage)
- Children (e.g., birth or adoption)

PLEASE LOGIN TO THE TRUST WEBSITE AT WWW.BERMT.COM AND CHECK YOUR CONTACT AND BENEFICIARY INFORMATION. THIS INFORMATION NEEDS TO BE UP-TO-DATE IN ORDER TO GET IMPORTANT NOTICES ABOUT THE PLAN AND YOUR BENEFITS.

See the Highlights of the Plan, on first page, for Trust Office contact information.

PART 5
SURVIVOR BENEFITS

5.1 What will the Personal Benefit Level be for my spouse and children in the event of my death?

A Surviving Spouse of an Eligible Retiree is entitled to receive a benefit equal to 100% of the deceased Employee's Personal Benefit Level, starting the month after the Employee would have attained the applicable eligibility age, 58 or 65 (see Part 2). If there is no Surviving Spouse, then Surviving Children are entitled to receive a benefit equal to 50% of the deceased Retiree's benefit level (to be divided among all Children), starting the month after the Employee's death.

5.2 What are the requirements for Spouse, Child, Surviving Spouse and Surviving Child status?

A Surviving Spouse is the lawful spouse of an Eligible Retiree, who has been the spouse of the Eligible Retiree for at least twelve (12) months on the date of death of the Eligible Retiree. The Spouse of an Employee, who has satisfied all the eligibility requirements in Q&A 2.1, except the applicable eligibility age, is also a Surviving Spouse.

A Surviving Child or Child is the natural child, legally adopted child, or stepchild of the Eligible Retiree, who is under age 26. Child or Surviving Child also includes a child of

the Eligible Retiree of any age who is totally disabled, as determined by the Social Security Administration.

Spouse includes any lawful spouse. Note that the Trust grants the same rights and benefits to same-sex spouses as it grants to opposite-sex spouses. Please keep the Trust Office notified of your marital status and your current spouse. Due to the cost of compliance with federal tax regulations and the required taxation of domestic partner benefits, the Plan does not provide benefits for domestic partners or surviving domestic partners.

PART 6
BENEFIT CLAIM AND APPEAL PROCEDURES

6.1 How do I submit my claims for benefits?

To present a claim for benefits under this Plan, the Eligible Retiree must submit a written claim, on a form supplied by the Trust Office, along with supporting documentation, to the Trust Office. Beneficiaries may contact the Trust Office to request an approved claim form.

The Eligible Retiree can submit claims for Covered Expenses of his or her legal Spouse and Children (see Q&A 5.2), but there is only one Personal Benefit Level per month for reimbursement of all Beneficiaries' claims. After the Eligible Retiree's death, the Surviving Spouse must submit the claims for reimbursement of his or her own Covered Expenses and the Covered Expenses of the Surviving Children.

Claims must be received by the Trust Office within 3 months after the end of the calendar year in which the Beneficiary paid the Covered Expense, i.e., by March 31st of the following year. So, for example, for a Covered Expense payment made on June 12, 2024, the claim must be submitted no later than March 31, 2025, and for a Covered Expense payment made on December 31, 2024, the claim must be submitted no later than March 31, 2025. If you think you have good cause for missing the deadline, contact the Trust Office. While the Trust Office may waive the deadline for good cause shown, please do not assume that any circumstances will constitute good cause.

Documentation Needed For Each Claim

The claim form must be accompanied by documentation from an independent third party, which includes the following:

- The date that the medical service or supplies were provided (which date must be prior to submission of the claim) or the dates of coverage for insurance premiums.

- A description of the medical service, supplies or premiums, which must qualify as a tax-deductible expense.

- Proof of the Beneficiary's payment of the Covered Expense, which includes one of the following:

    - Canceled check drawn to the name of the medical service, supplies, or insurance provider, bank statement showing check payment, or credit card statement showing payment.
    - Copy of confirmation of electronic payment to the medical service, supplies, or insurance provider.
    - Receipt for payment from the medical service, supplies, or insurance provider, including pension (CalPERS) statement showing premium deduction.
    - Other proof approved by the Board of Trustees.

Annual Claim Form For Premium Reimbursement

For insurance premium reimbursement claims, at least annually, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates of coverage for insurance premiums
- A description of the insurance premiums, i.e., type of insurance provided

The annual claim form will advise the Trust Office of the premium amount that you will be paying for the upcoming year, and the amount that you are claiming for reimbursement from the Plan for those monthly premiums. If you have a change in premium amount before the next annual claim form collection date (e.g., due to eligibility for Medicare or adding/deleting a family member to/from your policy), then you need to submit a new claim form to the Trust Office.

Documentation Needed For Each Premium Reimbursement (Monthly)

To receive reimbursement of recurring monthly premiums (except for Medicare premiums deducted from Social Security payments), you must also submit the following information each time you want reimbursement. This is in addition to the annual documentation with the claim form described above. Generally, you must submit proof that a Beneficiary has paid the premium each month, and the payment amount must match the amount claimed on your annual claim form. See examples of proof of payment above.

You can send proof of your payment monthly, or you can batch proof of payment documentation less frequently, as long as you comply with the annual claims deadline. However, you will only be reimbursed for months for which the Trust Office has received your proof of payment. If your premium amount changes before the next annual verification request from the Trust Office (most likely due to Medicare eligibility), you must submit a new claim form and third-party insurance documentation of your new premiums.

Documentation of Medicare Premiums Deducted from Social Security Payments (Annual Statement)

Because you receive only one annual statement showing the monthly deduction for Medicare payments, you can submit that statement annually with your claim form, and the Trust Office will reimburse you monthly for that amount, up to your Personal Benefit Level, for the rest of the year. **You do not need to submit any other documentation**, unless your Medicare premium is paid via check or ACH payment. This exception applies to all Medicare premiums, i.e., Parts A, B and D. Please note that the exception does not apply to Medicare Supplemental or Medigap premiums. If your Medicare premium changes during the year (e.g., a spouse is added to Medicare during the year or a spouse dies), then you must submit the new Social Security statement and a new claim form to the Trust Office within 30 days of receipt.

Annual Premium Payments

If you pay your insurance premium in one lump sum annually for an entire year of coverage, then you can submit a claim form, third party documentation of insurance coverage, and proof of premium payment just once per year after making your annual payment; you do not need to resubmit this same documentation each month. The Trust Office will reimburse your annual premium payment up to your Personal Benefit Level each month until the annual premium is reimbursed in full.

Claims Payments Must Reimburse Prior Covered Expense Payments

All reimbursement payments must reimburse your prior Covered Expense payment, not a prospective payment. If you request reimbursement of insurance premiums, you may be reimbursed in the month following the month in which you paid the insurance premium depending upon the date in the month that you pay your premiums.

You may *not* submit claims for medical expenses that have been paid, or you expect to be paid, by another source, such as Medicare, a supplemental health insurance plan, or a Health Savings Account (HSA). If such double coverage is discovered, the Trust may pursue recoupment, penalties and interest against you.

Overpaid Benefits

If the Trust Office overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments until the Trust has recouped the overpaid amount, or the Trust may seek repayment of the overpaid amount from you directly to the Trust.

Delegation of Authority for Family Member to Submit Claims

Beneficiaries can also authorize a family member to submit claims on their behalf. In this circumstance, the family member would help you to submit your claims to the Trust Office and sign the claims form on your behalf, but the Trust Office will still pay all benefit payments to the Beneficiary. (See Q&A 6.4 on prohibition of assignment of rights and claims.) You can contact the Trust Office to get a form for Delegation of Authority to Submit Claims. Please note that the signatures on the form must be notarized.

6.2 Where should I send my benefit claims, requests for clarification or determination of eligibility, complaints, and appeal hearing requests?

Please mail or email benefit claims to the Trust Office at:

Burbank Employees Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-mail: **burbankcity@bpabenefits.com**
Drop box on website **www.bermt.com**

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan, or enforcement of rights under the Plan. Details for claim submission and appeal of claim denial are set forth in Section 3.6 and Section 4 of the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

6.3 When should I expect a decision on my claim?

If your claim is received by the 10th of the month, it will be paid in that same month, provided it is sufficiently documented and approved by the Trust Office. If your claim is received after the 10th of the month, it will be paid in the next month. For example, if your claims is received on October 10th, it will be paid in October's claim payment; if it is received on October 11th, it will be paid in November's claim payment.

If your claim is not allowed under the Plan, the Trust Office will send you a written denial of your claim, explaining the reason for the denial and referencing the Plan provisions upon which the denial is based. Within 30 days of receipt of your claim, the Trust Office will review your claim and either: approve the claim and process it for payment; send you a written denial; send you a written notification of extension of time to determine the claim; or send you a written request for additional documentation or information to support your claim. If the Trust Office requests additional documentation or information, the Trust Office will give you 45 days to respond. If you do not respond within the 45-day period, your claim will be denied.

6.4 How do I appeal a claim denial or other adverse determination of the Trust Office?

To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, a Beneficiary must submit a written request to the Trust Office within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. An appeal is considered submitted and filed with the Trust Office on the date that it is received/date stamped at the Trust Office. The Board of Trustees will hold a hearing on the appeal, and the Beneficiary will be entitled to present his or her position and any evidence in support of his or her appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision. The Board of Trustees' decision on an appeal is final. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

The Trustees have broad discretionary authority to determine eligibility for benefits, to grant or deny claims for benefits, to interpret and apply the provisions of this Plan, 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 is binding and conclusive.

6.5 Is there a time limit for filing a lawsuit against the Trust for benefit payments, etc.?

Yes, there is a limitation period for filing a lawsuit against the Trust. A Beneficiary has the right to bring action in federal court pursuant to ERISA Section 502(a) no later than one year after the exhaustion of administrative remedies (i.e., the appeal process discussed in Section 6.1 above), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court. The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits, and the Trustees anticipate that an action brought in federal court challenging the Trustees' exercise of their discretionary authority will be subject to a deferential standard of review.

6.6 Can I assign my rights and benefits under the Plan to a medical provider or other entity?

No, the Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Covered Expenses you will submit to the Plan for payment. The Plan will not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. Details of this restriction are in Plan Section 3.7. (There is an exception for incompetent Beneficiaries with a court appointed representative. See Plan Section 3.6(h).)

6.7 What is a Qualified Domestic Relations Order (QDRO) or Qualified Medical Child Support Order (QMCSO) and who pays the costs of evaluating and implementing a QDRO or QMCSO?

The parties to a divorce proceeding can divide the monthly benefits earned during the marital period, but that division can only be implemented pursuant to a valid QDRO, as determined by the Plan. The Plan reserves the right to determine whether a domestic relations order is a QDRO. The Trustees have adopted procedures and a model QDRO for this purpose.

Upon notice of the intent to secure a QDRO, the Plan will segregate 50% of the community property benefits that the Employee earned during the marriage, and set those funds aside for potential future payment to the Alternate Payee (Employee's ex-spouse) after the QDRO is approved. The Plan will segregate the Alternate Payee's share of the Personal Benefit Level for no more than 18 months from the date that this segregation begins. If the Alternate Payee obtains a QDRO prior to the end of the 18-month period, the Plan will pay the Alternate Payee his or her share of the segregated benefits in accordance with the Plan's rules. If the Alternate Payee fails to obtain a QDRO within this 18-month period, the Plan will pay the segregated benefits to the Employee in accordance with the Plan's rules and will stop segregating future benefits.

A former spouse of an Employee under a QDRO, known as an Alternate Payee, may commence receiving his or her portion of the monthly Personal Benefit Level at a time specified in the QDRO, but no earlier than the earliest date that the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the Participating Employer on such date. An Alternate Payee's monthly benefits will not be suspended if the Employee returns to employment with a Participating Employer. An Alternate Payee's monthly benefits will terminate on the first of the month following the Alternate Payee's death.

The Surviving Children of the marriage of the Eligible Retiree and Alternate Payee may begin receiving benefits starting the month after the death of the Alternate Payee and such Surviving Children's benefits will terminate on the date the last Surviving Child no longer meets the definition of Child or the date of death of the last Surviving Child.

Beneficiaries can obtain from the Trust Office, without charge, a copy of the procedures governing the determination of whether a Domestic Relations Order is qualified.

A QMCSO is an order issued by a state court or agency that may require a health plan subject to ERISA to provide health benefits to children.

The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse as a deduction applied to the benefit payments or Employee Account balance. The costs include, but are not limited to, the

following: administrative costs for dividing the Benefit Level and setting up benefits for the ex-spouse; legal fees for evaluation of the court order and to advise the Trust Office on implementation of a QDRO or QMCSO; and actuarial fees to calculate the Benefit Level of the ex-spouse. The costs deducted from benefit payments of the Eligible Retiree and ex-spouse may vary from one divorce situation to another and may be spread amongst several months of benefit payments.

PART 7
ADMINISTRATION AND THE BOARD OF TRUSTEES

7.1 Who is the Plan Administrator?

The fiduciary of the Plan (known under federal law as the "Plan Administrator") is the Board of Trustees of the Burbank Employees Retiree Medical Trust. The Board has retained the services of a contract administrator ("Trust Office") to assist in recordkeeping, claims payments, etc. You may contact the Board in care of the Trust Office.

7.2 What are the names and addresses of the Trustees?

BCEA Trustees:	Robert Kaczmarek, Chair
	Pete Mejia
	Griselda Sandoval
BMA Trustees:	Chris White
	Teri Kaczmarek, Retiree, Secretary
IBEW Trustees:	Frank DiLiberto
	Barry Heller, Retiree

Trustees can be reached using the address of the Trust Office below in Section 7.3.

7.3 How can I contact the Trust Office?

You can contact the Trust Office at:

Burbank Employees Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-mail: **burbankcity@bpabenefits.com**
Toll Free Phone: (888) 806-8944

The Trust also has a webpage at **www.bermt.com** where you can access documents, forms and information about the Trust.

PART 8
GENERAL INFORMATION ABOUT THE PLAN AND TRUST

8.1 What are the official name and identification numbers of the Plan and Trust?

This Plan is known as the restated "Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust," restated effective August 1, 2024, and as amended thereafter (the "Plan"). It is funded through the Burbank Employees Retiree Medical Trust, which is governed by the "Trust Agreement Governing the Burbank Employees Retiree Medical Trust," effective April 1, 2003, and as amended thereafter (the "Trust Agreement"). For a copy of the Plan or the Trust Agreement, please contact the Trust Office.

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 01-6231970. The Plan Number is 501.

8.2 What is the Plan Year of the Trust?

The Plan year runs from January 1 to December 31.

8.3 What is the name, address and telephone number of the employee organization that established this Plan?

The Plan was established by the Burbank City Employees Coalition whose address and telephone number are:

Burbank City Employees Coalition
221 W. Alameda Ave., #103
Burbank, CA 91502
Attn: Robert Kaczmarek
Phone: (818) 843-8650

8.4 What type of plan is the Medical Expense Reimbursement Plan?

The Plan is a welfare benefit plan providing premium and medical expense reimbursement benefits to retirees. Beneficiaries may refer to Internal Revenue Service Publication 502, or check with the Trust Office to determine if a premium and/or medical expense is a permissible reimbursement under the Plan.

PART 9
PARTICIPATING ASSOCIATIONS AND CONTRIBUTIONS

9.1 Are there bargaining agreements that address this Plan and Trust?

Yes, the Plan is maintained pursuant to various collectively bargained Memoranda of Understanding ("MOUs"), and applicable successor agreements, between the bargaining units in the Burbank City Employees Coalition and the City of Burbank.

Beneficiaries of the Plan (i.e., Employees, Eligible Retirees, Surviving Spouses, and Children), as defined in the Plan and Trust documents, may examine MOUs at the Trust Office. In addition, Beneficiaries may obtain copies of the MOUs upon written request to the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the MOUs. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

9.2 What is the source of contributions to the Trust and method used for the accumulation of assets?

Contributions to this Plan must be non-elective, i.e., required by an MOU or other Special Agreement (except for COBRA contributions). They may be employer and/or employee contributions. They are transferred by the participating employers, based on the Memorandum of Understanding(s) with the participating Association(s), and by employees. Further, under certain limited circumstances, Beneficiaries may make COBRA self-payment contributions. The Board of Trustees has authority to determine whether to provide refund of contributions paid by a Participating Employer on your behalf and the terms that will apply to such refund, subject to applicable law.

Contributions are received by and held in trust by the Trust and are invested with the assistance of a professional investment manager, utilizing investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 (ERISA) requirements.

PART 10
LEGAL RIGHTS

10.1 What is the name and address of the agent for service of process?

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Trustee or the Trust Office. The Trust Office street address for service of process is:

Burbank Employees Retiree Medical Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017

10.2 What are my legal rights under the applicable federal statutes?

A. Family Medical Leave Act

Please contact the Trust Office and/or your Employer if you would like to learn more about the right to self-pay contributions during FMLA leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

B. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If your contributions to this Plan cease due to a leave of absence for active duty military service, you have the right under USERRA to self-pay contributions for up to 24 months of that period of leave. If you would like to take advantage of your rights under USERRA, contact the Trust Office for details. Regardless of whether or not you elect to self-pay contributions under USERRA, the Plan will preserve all Active Service that you earned prior to your period of leave and that Active Service will be added to any future Active Service that you earn after return to City employment following your leave of absence.

C. Consolidated Omnibus Budget Reconciliation Act (COBRA)

A Qualified Beneficiary must provide written notice of the following Qualifying Event(s) to the Trust Office by either first class mail or facsimile (fax):

- ❖ Divorce or Legal Separation;
- ❖ Loss of Child Status;
- ❖ Notice of a Second Qualifying Event
- ❖ Disability;
- ❖ Change of Disability Status

Please see Section 4 of the COBRA General Notice attached to this SPD for the notice deadlines related to specific Qualifying Events.

If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions.

All COBRA Qualifying Events occur when there is a loss of contributions to the Plan, or loss of benefits from the Plan, due to a particular event designated in the COBRA statute.

For a full description of your rights under COBRA, please see the General COBRA Notice, provided at the end of this Summary Plan Description. If you would like to request a copy of the General COBRA Notice, please contact the Trust Office.

D. Qualified Medical Child Support Order (QMCSO)

Beneficiaries can obtain, without charge, a copy of such procedures governing the determination of QMSCO; contact the Trust Office.

E. Important Information: Statement of Legal Rights

❖ Rights of Plan Participants. Beneficiaries of the Burbank Employees Retiree Medical Trust are entitled to certain rights and protection under the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine without charge at the Plan Administrator's Office and at other specified locations, such as worksites and union halls, all documents governing this Plan, including MOUs, insurance contracts and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.

- If there is a cessation of contributions to the Plan as a result of a COBRA qualifying event, you or your family members may have to continue such contributions by self-payment. Review the General COBRA Notice and the Plan, Sections 2.2(b) and 2.2(c), for rules governing your COBRA continuation coverage rights.

❖ Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of this employee welfare benefit plan. These persons who operate your Plan and Trust are called "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan Beneficiaries, and they must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Trust. No one, including an employer, may fire or otherwise discriminate against members to prevent them from obtaining a welfare benefit or exercising their rights under ERISA.

❖ Enforce Your Rights. If a claim for a welfare benefit is denied or ignored, in whole or in part, Beneficiaries have a right to know why this was done, obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there

are steps that can be taken to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim to be frivolous.

- Assistance with Your Questions. If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

  You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272).

- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special precautions of health benefit plans to protect the privacy of "protected health information." In the course of providing benefit to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. A copy of the Privacy Notice is attached at the back of this Summary. If you would like more details about your privacy rights or another copy of the Privacy Notice, please contact the Trust Office.

COBRA GENERAL NOTICE

Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust

<< IMPORTANT COBRA INFORMATION >>
THIS COBRA INFORMATION WILL INFORM YOU OF YOUR RIGHTS AND OBLIGATIONS UNDER COBRA. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

Under this type of health plan, i.e., a retiree medical expense reimbursement plan, COBRA benefits mean the right to continue contributions to the Trust, in order to obtain certain Plan benefits after retirement. This Plan gives the Employee (or family member) the right to self-pay contributions into the Trust, which were formerly paid pursuant to a collective bargaining agreement or other special agreement while the Employee was working. The Employee, generally, has the right to continue self-payments for 18 months, and the family member, generally for 36 months.

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of your medical expense costs after retirement,[5] rather than health benefits immediately following active employment. That is, this Plan is for retiree health benefits, not benefits soon after termination of active employment.

1. COBRA Generally. You are a participant in the "Medical Expense Reimbursement Plan" (hereafter the "Plan") of the Burbank Employees Retiree Medical Trust (hereafter the "Trust"), which provides reimbursement towards certain medical expenses, as defined in the Plan, after retirement. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[6]

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUTIONS UNDER COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

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[5] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay coverage to terminated Employees until retirement. The Plan accepts contributions during active employment, which are held by the Trust and will be used by Employees to purchase health coverage after retirement. In the event of the Employee's death, payments to the Surviving Spouse will commence the month after the Employee would have attained the applicable eligibility age.

[6] Public Law 99-272, Title X.

2. COBRA Coverage Means the Right to Self-pay Continued Contributions to Plan for Benefits After Retirement.

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Trust by self-payment, when contributions to the Trust would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying Event, the Plan must offer each person who is a "Qualified Beneficiary" the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a collective bargaining agreement or special agreement. By offering a Qualified Beneficiary this right, generally, the Plan is offering that individual the ability to increase his or her benefits from the Plan in one of two ways:

i. the ability to meet the eligibility requirement to receive a lifetime[7] monthly reimbursement benefit from the Plan, which he/she may not otherwise have been able to meet (see **Section 2(B)** below); and/or

ii. To augment their monthly benefit, if the person already met the eligibility requirement.

You, your spouse, and your children could become Qualified Beneficiaries if contributions to the Trust on behalf of the covered employee cease due to a Qualifying Event.

B. Plan Eligibility Requirements. To be eligible to receive these medical expense reimbursement benefits after retirement, this Plan requires that the Employee earn five (5) years of Active Service as defined in Section 2.2 of the Plan. Therefore, making COBRA self-payments could make you eligible, depending on how many years of Active Service you have earned at the time of the Qualifying Event. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7** below.

Further, since the Plan also provides for a gradually increasing level of benefits based on the number of years of your contributions, you may be able to increase your monthly benefit level if you make additional contributions. We urge you to consult with your personal tax advisor on this matter. Note that the contributions will be made with taxable income. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7** below.

[7] The Plan is currently written to provide benefits for most Retirees until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of the Plan.

C. Consequences of Non-Election. If you do not choose to continue contributions to this Plan and you have not earned five years of Active Service, you will forfeit any benefits, contributions made, and Active Service earned under this Plan.

D. Widowed spouses and Children. Widowed spouses and Children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in **Section 5** below for details.

3. Qualifying Events and Qualified Beneficiaries.

A. An Employee as a Qualified Beneficiary. If you are an **Employee**, you will become a Qualified Beneficiary and have the right to self-pay contributions for yourself (and your beneficiaries), if contributions to the Trust on your behalf cease due to any of the following "Qualifying Events:"

i. Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or

ii. Reduction of Work Hours. Your hours of employment are reduced.

Either of these Qualifying Events generally gives you the right to continue self-payment of contributions to this Plan.

B. The Spouse as a Qualified Beneficiary. If you are the **spouse of an Employee** covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Trust on your spouse's behalf cease due to any of the following "Qualifying Events,"[8] and provided that the Employee does not elect to self-pay contributions under COBRA*:

i. Spouse's Death. The death of your spouse; or

ii. Termination of Spouse's Employment. A termination of your spouse's employment (for reasons other than gross misconduct);

iii. Reduction of Spouse's Work Hours. A reduction in your spouse's hours of employment, provided that your spouse does not elect to self-pay contributions under COBRA; or

iv. Divorce. If the Employee and spouse divorce during contributions or during benefit payments, a QDRO will provide more rights to ongoing and future benefit payments than COBRA, but this is a Qualifying Event for COBRA.

[8] Some health plans recognize the Qualifying Event of loss of coverage due to eligibility for Medicare benefits. However, there is no loss of coverage upon eligibility for Medicare under this Plan. In fact, the Plan reimburses premiums for Medicare Part A, B and D, and medical expenses not covered by Medicare.

*NOTE: Only one member of a family may make self-payment contributions in this type of health plan. If there are multiple Qualified Beneficiaries, for example a former employee and a spouse, you should confer together and decide whether electing to make COBRA self-pay contributions makes sense in your case, and which of you will make the election. It is important to note that due to the nature of this type of Plan, you do not each have independent rights to elect self-payment. This means that only one Qualified Beneficiary can self-pay.

C. If you are a **Child of an Employee** covered by this Plan, you may become a Qualified Beneficiary and have rights to self-pay contribution to this Plan if contributions to the Trust on your parent's behalf cease due to any of the following Qualifying Events, and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

i. Death of Parent. The death of the covered parent; or

ii. Termination of Parent's Employment. The termination of the covered parent's employment (for reasons other than gross misconduct);

iii. Reduction of Parent's Work Hours. A reduction in the parent's hours of employment, where neither the employee parent nor spouse elect to self-pay contributions under COBRA; or

iv. Loss of Child Status. If a Child attains age 26 and loses current reimbursement benefits under the Plan because he/she no longer qualifies as a Child under the Plan.

*See "Note" under **Section 3(B)** above.

4. Notification of Qualifying Event.

A. Employer's Notification Responsibility. The Plan will offer the COBRA option to self-pay contributions to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** has the obligation to notify the Plan Administrator of the Qualifying Event. However, we encourage the employee to also give notice to the Plan, in case the employer fails to do so.

B. Qualified Beneficiary's Notification Responsibility. Under COBRA, the **Employee or a family member has the responsibility** to provide written notice, within the time limits described in **Section 4(C)** below, to the Trust Office of the occurrence of any of the following Qualifying Events:

i. Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan;

ii. Divorce of the Employee and spouse;

iii. The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to self-pay contributions under COBRA for a maximum period of eighteen (18) months (or twenty-nine months in the case of a disability, as described in **Section 6** below);

iv. A Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or

v. A Qualified Beneficiary, who was determined as disabled is subsequently determined by the Social Security Administration as no longer disabled.

C. Timing Requirements for Qualified Beneficiaries to Notify the Trust Office of Qualifying Events.

i. Qualifying Events Other Than Disability. The period of time for providing notice to the Trust Office for the occurrence of a second Qualifying Event, is **sixty (60) days after** the latest of:

(a) *Qualifying Event*. The date that the Qualifying Event occurs; or

(b) *Contributions to the Trust Cease*. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

(c) *The Date you Receive Notice*. The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see **Section 5** below).

ii. Qualifying Event of Disability. The period of time for providing notice to the Trust Office of a disability determination is **sixty (60) days after** the latest of the following events (but no later than the end of the first eighteen months period of self-payment contributions):

(a) *Determination by Social Security Administration*. The date of the disability determination by the Social Security Administration.

(b) *Disability*. The date that the disability occurs;

(c) *Contributions to the Trust Cease*. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

(d) *The Date you Receive Notice*. The date that you are informed through this Notice of your responsibility to provide notice to the Trust

Office and the Plan's procedures for providing such notice (see **Section 5** below).

iii. Change of Disability Status. The period of time for providing notice to the Trust Office of a change in disability is **thirty (30) days after** the latest of:

(a) *Determination by Social Security Administration*. The date the Social Security Administration determines that you are no longer disabled; or

(b) *Notice of Responsibility and Procedure*. The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice to the Trust Office (see **Section 5** below).

5. Procedures for Notifying Plan of Qualifying Event. Subject to the time limits in **Section 4(C)** above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s), described in **Section 4(B)** above, to the Trust Office by either first class mail, e-mail, or facsimile (fax). The contact information for the Trust Office is as follows:

Burbank Employees Retiree Medical Trust
c/o Benefits Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-Mail: **Burbankcity@bpabenefits.com**

The notice of the Qualifying Even should include:

A. Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

B. Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

C. Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

When the Trust is notified that one of these Qualifying Events has occurred, it will, in turn, notify you about details concerning your election to continue your contributions to the Trust for the right to receive future benefits.

6. Maximum Length of COBRA payments. Once you have elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within forty-five (45) days of your election. Subsequent periodic payments must be made on a monthly basis and are due on the first of each month, but no later than thirty (30) days following the first of the month. **You will not receive monthly reminders that payment is due**.

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment of contributions.

i. Eighteen (18) month period. When the Qualifying Event is a termination of employment or reduction in hours of employment, the law requires that you be given the opportunity to self-pay contributions for eighteen (18) months.

ii. Thirty-six (36) month period. When the Qualifying Event is death of the covered employee, divorce, or loss of child status, the COBRA law requires that you be given the opportunity to continue to make contributions to the Trust by self-payment for thirty-six (36) months (three years).

B. Second Qualifying Event Extension (18 month extension of the initial 18 month period). If a second Qualifying Event, other than termination of employment, occurs during the eighteen (18) month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to eighteen (18) months of self-payment contributions, for a maximum of thirty-six (36) months. See **Sections 4 and 5** relating to notification requirements and procedure in the case of a second Qualifying Event.

C. Disability Extension (11 month extension of the initial 18 month period). If a Qualified Beneficiary under the Plan is determined by the Social Security Administration to be disabled, the Plan beneficiaries may be eligible to self-pay for an additional eleven (11) months, for a total of twenty-nine (29) months. The disability would have to have started at some time before ethe 60th day of the COBRA self-payment contributions and must last at least until the end of the 18-month period of self-payment contributions. See **Sections 4 and 5** relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional eleven (11) months may be approximately 50% higher than the amount of the first eighteen (18) months if the self-payment contributions include a disabled beneficiary and the extension of period for self-payment contributions would not be available in the absence of a disability.

7. Termination of COBRA Payments. The COBRA law provides that your right to continue COBRA payments may be terminated prior to the full self-payment period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

A. The Trust no longer maintains the Plan; or

B. Your employer no longer contributes to the Plan on behalf of employees; or

C. The monthly self-pay contribution to the Trust under COBRA is not paid timely; or

D. There has been a final determination that you are no longer disabled if you qualified to make an extra eleven (11) months of self-pay contributions based on disability.

You do not have to show that you are insurable to choose continued participation.

8. Refund of Contributions Erroneously Paid. Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Plan Administrator and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to self-pay contributions. Any Active Service or Contribution Credits granted based on an erroneous self-paid contribution will be rescinded.

9. Questions about COBRA. If you have any questions about the Plan or your COBRA continuation self-payment rights, you should contact the Trust Office at the address, email, and/or phone number appearing below:

Burbank Employees Retiree Medical Trust
c/o Benefits Programs Administration
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA 90017
E-Mail: **Burbankcity@bpabenefits.com**
Phone: (213) 406-2350
Toll Free Phone: (888) 806-8944

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**.

10. Address Changes. In order to protect your family's rights, you should keep the Plan administrator informed of any changes in marital status or address of yourself and family members. Send all address changes to the Trust Office address stated in **Section 9** above. You should also keep a copy for your records of any notices you send to the Plan Administrator.

BURBANK EMPLOYEES REITREE MEDICAL TRUST
NOTICE OF PRIVACY PRACTICES
WITH RESPECT TO PROTECTED HEALTH INFORMATION

Introduction. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to information, called protected health information, that identifies a particular individual and relates to the past, present, or future physical or medical condition of the individual, provision of health care to the individual, or payment for the provision of health care to the individual. The Burbank Employees Retiree Medical Trust is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the manner in which it may be used or disclosed.

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.

I. Our Duties Concerning Protected Health Information. As the administrative agent for the Board of Trustees of the Trust, the Trust Office is required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We are also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations about which you can obtain further information by contacting the Privacy Contact Officer identified in Section VII of this Notice.

If any applicable state or federal law imposes limitations upon uses and disclosures of protected health information that are more stringent than the limitations imposed under the Privacy Rule, we are required to adhere to those more stringent limitations.

II. Uses and Disclosures for Treatment, Payment, and Health Care Operations. Except with respect to uses or disclosures that require an authorization as described in Section IV of this Notice, we may use or disclose protected health information for treatment, payment, or health care operations, as set forth in Paragraphs II(A) – II(D) below, without obtaining your consent. We may elect to obtain your consent to use or disclose protected health information for such purposes, although we are not required to do so. Moreover, such consent shall not be effective to permit a use or disclosure of protected health care information that requires an authorization as described in Section IV of this Notice.

A. For our payment of premium reimbursement claims. Payment includes but is not limited to actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to premium reimbursement.

B. For the payment activities of another covered entity or health care provider to whom we disclose the information. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. To another covered entity for health care fraud and abuse detection or compliance or health care operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains and information disclosed pertains to that relationship.

D. To disclose protected health information to the Board of Trustees of the Trust, as the plan fiduciary, as necessary for Trust administration. The Board has signed a certification, agreeing not to use or disclose protected health information other than as permitted by the Plan documents, or as required by law.

III. Other Uses and Disclosures Permitted or Required Without Authorization. We may, by complying with the requirements specified in the Privacy Rule, use or disclose protected health information without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

A. When and to the extent such use or disclosure is required by law.

B. For public health activities or public health oversight authorized by law.

C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.

E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, reporting crime in emergencies, or if the information constitutes evidence of criminal conduct on our premises.

F. For coroners, medical examiners, and funeral directors to perform their legal duties.

G. For procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

H. For research purposes where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.

J. For specialized government functions related to military personnel, veteran's benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.

K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.

L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information, if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

IV. Authorization Required for Other Uses and Disclosures. Uses and disclosures of protected health information other than those identified above will be made only with your written authorization.

You may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or the policy itself.

V. Individual Rights. All participants have the following rights with respect to protected health information that the Plan maintains about them:

A. Restrictions on Uses and Disclosures. You may request that we restrict uses or disclosures of protected health information for the purposes of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care.

We are required to agree to your request only if the disclosure is for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) for a health care item or service for which you have paid the health care provider out-of-pocket in full.

Except as described above, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement with respect to protected health information, created or received after we have notified you of the termination. Until then we will be required to abide by the restriction unless the information is required for purposes such as giving you emergency treatment, assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name in a health care facility directory if you are incapacitated or in emergency circumstances, and circumstances described in Section III of this Notice in which an opportunity to agree or object need not be provided.

B. Confidential Communications. We must accommodate reasonable requests to have protected health information communicated to you in confidence by alternative means

or at alternative locations. We may require your request to be in writing, state if appropriate how payment for the accommodation will be handled, specify an alternative method of contacting you, and state that disclosure of all or part of the protected health information could endanger you.

C. Access for Inspection and Copying. You may request access to inspect or copy protected health information that is maintained about you in a designated record set. If we grant your request, we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and costs to which you have agreed in advance for preparing an explanation or summary. If we deny your request in whole or in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other protected health information subject to your request.

We may in some circumstances deny your request without providing an opportunity for review, as when the information consists of psychotherapy notes or was compiled for use in a legal or administrative proceeding, and certain other circumstances. There are other circumstances in which we must provide an opportunity for review of our denial, as when the denial is based upon a determination that provision of the information is likely to cause substantial harm to you or another person. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services, or the Privacy Contract Officer identified in Section VII of this Notice if you believe our denial was improper.

D. **Amendments**. You may request amendments to protected health information maintained about you in a designated record set. If we accept your request in whole or in part, we must identify the information affected thereby provide a link to the amendment, and make reasonable efforts to notify within a reasonable time person disclosed by you or known to us who might foreseeably rely on the information to your detriment. We may deny your request if we determine that the information subject to your request is already accurate and complete, is not part of the designated record set, would not be available for inspection as described in Paragraph V(C) above, was not created by us, and in certain other circumstances.

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link to the request, our denial, and any statements of disagreement and rebuttal. We will also be required if asked by you to include your request for amendment and our denial with any future disclosures of the information subject to your request. If you submit a statement of disagreement, we will be required to include your request for amendment, our denial, your statement of disagreement, and any rebuttal statement with any subsequent disclosure of the information to which the disagreement relates. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the

Department of Health and Human Services or the Privacy Contract Officer identified in Section VII of this Notice if you believe our denial was improper.

E. Accountings of Disclosures. You may obtain an accounting of our disclosures of protected health information about you during any period up to six years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same 12-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

F. Paper Copies of this Notice. Regardless of the form in which you have chosen to receive this Notice from us, you may receive a paper copy at any time from the Privacy Contact Officer identified in Section VII.

VI. Changes to Privacy Practices. We must change our privacy practices when required by changes in the law. We reserve the right to make other changes to our privacy practices or to this Notice that comply with the law. Whenever a change to our privacy practices materially affects the contents of this Notice, we will prepare a revised Notice and send it within 60 days to individuals then covered by the Plan. The Privacy Contact Officer identified in Section VII will also provide a current copy of this Notice upon request. A change to our privacy practices that requires a revision of this Notice may not be implemented before the effective date of the revised Notice. However, we reserve the right to make the terms of any revised Notice effective for all protected health information that we maintain.

VII. Additional Information and Complaints. You may as specified below obtain additional information and/or submit complaints regarding our duties and your rights with respect to protected health information:

A. Privacy Contact Officer. The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy Contact Officer whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice:

Privacy Contact Person
c/o Benefit Programs Administration
E-mail: **burbankcity@bpabenefits.com**
Phone: (213) 406-2350
Toll Free Phone: (888) 806-8944

B. Privacy Complaints. You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Officer or the Secretary of the Department of Health and

Human Services, Hubert Humphrey Building, 200 Independent Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

C. No Intimidation or Retaliation. No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a Privacy Complaint.

VIII. Effective Date. This Notice is effective on the 1st day of January 2018, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section VI.

PHI use and disclosure is regulated by federal law, 45 CFR parts 160 and 164, subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.

From: BOARD OF TRUSTEES
BURBANK EMPLOYEES
RETIREE MEDICAL TRUST
Trust Office phone number: (213) 406-2350