AMENDMENT NO. 16
TO THE
MEDICAL EXPENSE REIMBURSEMENT PLAN
OF THE
CENTRAL VALLEY RETIREE MEDICAL TRUST

The Board of Trustees of the Central Valley Retiree Medical Trust (the "Trust") does hereby amend the Medical Expense Reimbursement Plan, restated effective January 1, 2021 (Dr. 11/17/20) (the "Plan"), as follows:

1. **Update to Limits on Rebates or Refunds as Allowed By Law.** Section 2.3 is deleted and revised to read as follows:

"**2.3 No Rebate or Refund.** Beneficiaries shall receive benefits from the Plan only as reimbursement of Covered Expenses. No Beneficiary or Employee shall be eligible for rebates or refunds of any contributions made, except as reimbursement of Covered Expenses. As permitted by applicable law and approved by the Board of Trustees, any elective contributions (other than under COBRA or USERRA) will be refunded upon discovery that the contribution was made by individual election. Beneficiaries are not entitled to Active Service based on an elective contribution, regardless of whether the contribution is refunded."

2. **The Plan's Right to Reimbursement for Overpaid Benefit Payments.** Subsection 3.1(b) is deleted and revised to read as follows:

"(b) Recoupment of Overpaid Benefits. If the Trust overpays benefits in regard to a Beneficiary, the Trust Office, as directed by the Trustees, shall have the right to request repayment of the overpayments from the Beneficiary. If the Beneficiary fails to repay the Trust for the amount of the overpayment, the Trust Office, as directed by the Trustees, shall have the right to recoup the overpaid amount from the Beneficiary's future benefit payments. The Beneficiary will be obligated to repay the Trust for overpaid benefits, as requested by the Trustees. This section will be administered as allowed by law."

3. **Timing for Trust Office's Claim Decision.** Section 4.2 is deleted and revised to read as follows:

"**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 a Beneficiary not later than thirty (30) days after receipt of the Beneficiary's claim. This thirty (30) day period shall commence upon the Trust Office's receipt of a claim form or other request for reimbursement from the Beneficiary, irrespective of whether the Beneficiary has provided all of the documentation and information necessary for it to determine the claim. If coverage is granted, the Beneficiary shall receive payment as stated in Section 3.3. 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 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;

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

(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 a Beneficiary upon request;

(6) 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 exhausting the Plan's appeal procedures; and

(7) A description of the Plan's limitation period for filing a lawsuit against the Plan for benefit payments, as stated in Section 4.4(b) hereof.

(b) Extension of Time – Special Circumstances. If the Trust Office determines 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 thirty (30) day period referenced in Section 4.2(a) hereof. The Trust Office's extension notice shall: (i) inform the Beneficiary that it needs the extension; (ii) explain the special circumstances that require the extension; (iii) identify any additional information it may need from the Beneficiary (if the extension is needed due to insufficient information); and (iv) confirm the date by which the Trust Office expects to render a benefit determination. In no event shall such extension exceed a period of fifteen (15) days from the end of the initial 30-day period. In the event that additional information is needed from the Beneficiary and the Beneficiary fails to submit all necessary information and documentation to allow the Trust Office to decide the claim by the end of the tolling period in Section 4.2(c) hereof, the Trust Office may not further extend the time for making its

decision on the claim, unless the Beneficiary agrees in writing to further extend the deadline.

(c) Tolling of Claim Determination for Time to Submit Claim Information and Documentation. The Beneficiary shall be allowed at least forty-five (45) days from his or her receipt of the Trust Office's request for additional information within which to provide the Trust Office with the additional information requested. In such case, the 15-day extension period, and any remaining portion of the initial 30-day period, for the Trust Office to decide the claim is tolled from the date on which the request for additional information is received by the Beneficiary. This tolling period shall expire on the earlier of: (i) the date that the Trust Office receives a response from the Beneficiary, without regard to whether the Beneficiary's response provides all of the information and documentation requested and necessary for the Trust Office to decide the claim; or (ii) the date of the deadline established by the Trust Office for the Beneficiary to furnish the requested information (*i.e.*, at least 45 days from the Beneficiary's receipt of the request). Nothing in this Section shall preclude the Beneficiary from voluntarily agreeing to provide the Trust Office additional time within which to make a decision on a claim."

Approved by the Board of Trustees on June 2, 2023, and effective as of June 2, 2023.

For the BOARD OF TRUSTEES,
CENTRAL VALLEY RETIREE MEDICAL TRUST

Trustee

Trustee

Matt Potter
Print Name

Juan Flores
Print name