Transportation Communications International Union

and

Los Angeles County Metropolitan Transportation Authority

Health and Welfare Trust Fund

Summary Plan Description

For Active and Retired Employees and their Dependants

March 2016

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Communications
International Union

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For Active and Retired Employees and their Dependents

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TRANSPORTATION COMMUNICATIONS INTERNATIONAL UNION - LOS ANGELES COUNTY METROPOLITAN TRANSPORTATION AUTHORITY HEALTH AND WELFARE TRUST FUND

13191 Crossroads Parkway North, Suite 205
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TRANSPORTATION COMMUNICATIONS INTERNATIONAL UNION - LOS ANGELES COUNTY METROPOLITAN TRANSPORTATION AUTHORITY HEALTH AND WELFARE TRUST FUND

To all Employees and Retirees covered by the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund:

We are pleased to present you with this new Summary Plan Description ("SPD"), which sets forth the Plan of Benefits (the "Plan") provided by the Transportation Communications International Union – Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund (the "Trust"). This SPD contains all changes to the Plan as of March 1, 2016. It replaces all previous SPDs.

This SPD will advise you of several matters concerning the benefits provided by the Trust including:

- How to become eligible for Plan benefits,
- What benefits are provided by the Trust,
- What is excluded from coverage, and
- How to file a claim for benefits and appeal a denied claim.

You are encouraged to share this SPD with your family since they also have an interest in the benefits available through the Trust. Since many changes have been made since the printing of the last SPD, you are urged to familiarize yourself with the benefits available and your rights to those benefits. Please note, however, that in the event of a conflict between this SPD and the Trust's Trust Agreement, the Trust Agreement shall control.

If you have any questions concerning your benefits, please contact the Administrative Office.

Sincerely,
BOARD OF TRUSTEES
March 2016

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BENEFIT CHARTS

I.

IMPORTANT INFORMATION

A. Authorized Sources of Information

If you have any questions about your benefits, you may only rely upon: (1) this SPD, the Rules and Regulations, the Trust Agreement, and any supplements and amendments thereto; and (2) the written statements of the Board of Trustees or the Administrative Office, You may not rely on any oral statements. Furthermore, written representations made by individuals other than the Board of Trustees or the Administrative Office are not authoritative sources of information. Questions as to eligibility, benefits, and other matters regarding the Plan should be submitted in writing to the Administrative Office at: Benefit Programs Administration, 13191 Crossroads Parkway North, Suite 205, City Of Industry, California 91746-3434.

B. Availability of Trust Resources

The benefits provided by the Trust can be paid only to the extent that the Trust has available adequate resources for such payments. The Los Angeles County Metropolitan Transportation Authority (the "MTA") does not have any liability, directly or indirectly, to provide these benefits beyond its obligation to make contributions as stipulated in the collective bargaining agreement with Transportation Communications International Union Local 1315 (the "Union").

The benefits provided by the Trust under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefit are not insured by any contract of insurance, and there is no liability on the Trust, the Board of Trustees, or any other individual or entity to provide payment over and beyond the amount in the Trust collected and available for such purpose.

C. Amendment and Termination

The Board of Trustees expressly reserves the right, in its sole discretion and at any time:

- To terminate or amend the amount of, or eligibility for, any benefit provided under the Plan, even though such termination or amendment affects claims which have already accrued;
- To terminate the Plan, even though such termination affects claims which have already accrued;
- To alter or postpone the method of payment of any benefit; and

- To amend or rescind any other provisions of the Plan.

D. Mistake

If the Trust pays benefits for or on behalf of you or any person listed or claimed as your Dependent, you must promptly reimburse the Trust for any benefits so paid if either:

- You or such person is not eligible or entitled to the benefits; or
- The Trust otherwise mistakenly pays such benefits.

If you do not reimburse the Trust, the Board of Trustees, in their sole discretion, may deduct or offset any such monies from your future benefits. If the Trust files any legal action against you to recover any such monies, you are required to pay all attorney fees and costs of the Trust, whether or not such an action proceeds to judgment.

E. Discretion

The Board of Trustees is vested with the power and discretion to: (1) interpret the Trust Agreement, this SPD, any other document governing the Plan, and any amendments thereto; and (2) construe any facts relating to the application of the Plan. The Board of Trustee's interpretation is final and conclusive.

II.

ELIGIBILITY RULES

A. Eligibility for Coverage

1. Full Time Active Employees ("Full Time Employees")

You are eligible for benefits under the Trust as a "Full Time Employee" beginning on the first day of the month coinciding with or following the date on which you have completed 60 days of continuous employment if you satisfy all of the following requirements:

- You are an active full-time employee of the MTA, as determined in accordance with the collective bargaining agreement between the Union and the MTA.

- You are covered by the terms of the collective bargaining agreement between the Union and the MTA.

- You pay a participant contribution to the Trust, in an amount determined by the Trustees, for each month of eligibility. (Participant contributions to the Trust will be deducted automatically by the MTA through payroll deduction.)

Your eligibility may continue while you are on an approved leave of absence or on an authorized sick leave, in accordance with Section D of this Article II.

2. Part Time Active Employees ("Part Time Employees")

You are eligible for benefits under the Trust as a "Part Time Employee" beginning on the first day of the month coinciding with or following the date on which you have completed 60 days of continuous employment if you satisfy all of the following requirements:

- You are an active part-time employee of the MTA, as determined in accordance with the collective bargaining agreement between the Union and the MTA.

- You are covered by the terms of the collective bargaining agreement between the Union and the MTA.

- You pay a monthly participant contribution, in an amount determined by the Trustees, for each month of eligibility. (Participant contributions to the Trust will be deducted automatically by the MTA through payroll deduction.)

Part Time Employee benefits do not include coverage for Dependents.

3. Retired Employees ("Retirees")

You are eligible for benefits under the Trust as a "Retiree" if you satisfy all of the following requirements:

- You are retired from active employment with the MTA and/or its predecessors.
- You are less than 65 years of age.
- You have completed at least 23 years of service with the MTA and/or its predecessors as a Full Time Employee
- You pay a participant contribution on a quarterly basis, in an amount determined by the Trustees, for each 3-month period of eligibility. (The Trust will bill you for your participant contribution each quarter.)

4. Dependents of Full Time Employees and Retirees ("Dependents")

Your spouse, Domestic Partner, and children are eligible for benefits under the Trust as "Dependents" if all of the following requirements are satisfied:

- You are an eligible Full Time Employee or Retiree.
- You elect to cover your Dependents.
- You pay a monthly dependent contribution, in an amount determined by the Trustees, for each month of Dependent coverage. (For Full Time Employees, this dependent contribution will be automatically paid to the Trust by the MTA through payroll deduction. If you are a Retiree, you must self-pay dependent contributions in accordance with Plan rules.)

The Plan defines "Dependent" as:

1. Your lawfully married spouse or registered Domestic Partner.
2. Your unmarried child who is 25 years of age or younger, including:
   - Your legally adopted child or foster child or those of your spouse or Domestic Partner
   - Your stepchild (i.e., the child of your lawfully married spouse or Domestic Partner)
   - A child for whom you, your spouse, or your Domestic Partner have been designated the court appointed legal guardian or conservator.

Proof of legal guardianship or conservatorship must be submitted to the Administrative Office upon request.

3. Your unmarried child who is 26 years of age or older, if the child is disabled and incapable of self-sustaining support as a result of mental retardation or physical handicap that occurred prior to reaching age 26. Written evidence of disability must be submitted within 31 days of attainment of the age limit and must be periodically reconfirmed to the Administrative Office upon request. This disability extension will continue until the earlier of: (1) the date the child ceases to be eligible for reasons other than age; (2) the date the child ceases to be disabled; or (3) the 31st day after the Trust requests additional proof of the child's disability and you fail to furnish such proof.

5. Payment of Participant Contributions via the Flexible Benefits Plan

The amount of your monthly participant contribution counts as income to you and therefore is subject to federal and state income tax. However, you can avoid this tax liability by enrolling in the Transportation Communications Union Local 1315 Flexible Benefits Plan offered by the MTA. The Flexible Benefits Plan will transfer your monthly participant contribution to the Trust. This will save you money, because you will not have to pay income taxes on the amounts transferred to the Trust through the Flexible Benefits Plan.

6. Special Rule Pertaining to Dependent Spouse Coverage

The spouse or Domestic Partner of a Full Time Employee or Retiree, who is covered under the Trust as an enrolled Dependent, will have "secondary coverage" (and not "primary coverage") under the Plan's Coordination of Benefits rules, but only if the employer of such spouse or Domestic Partner makes health care insurance available to the spouse or Domestic Partner. See Article XVI, pp. 50 to 51 for an explanation of these rules.

7. Effective Date of Dependent Coverage

If a Dependent has been properly enrolled and payroll deductions have been authorized on the Dependent's behalf:

An existing Dependent becomes eligible for coverage on the same date that the Full Time Employee or Retiree becomes eligible.

A new Dependent becomes eligible on the first of the month following the date he or she has satisfied the Dependent coverage requirements. Newborns, however, are eligible as of the date of birth. **All new Dependents must be enrolled within 30 days of becoming a Dependent.**

8. Qualified Medical Child Support Order

Special rules apply to Dependent children added to the health coverage of an Employee or Retiree under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order requiring the Plan to provide health coverage for a child of an Employee or Retiree who is typically involved in a divorce. Please contact the Administrative Office if you need further information regarding QMCSOs or the Plan's procedures regarding QMCSO determinations.

9. Special Enrollment Rights under HIPAA

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or your Dependent(s) (including your spouse) because of other health insurance or group health plan coverage, you may, in the future, be able to enroll yourself and/or your Dependents in this Plan, provided that you request enrollment within 30 days after you or your Dependents lose eligibility for that other coverage (or the employer stops contributing towards your or your Dependents' other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or your Dependent(s) (including your spouse) because of coverage under Medicaid or a state children's health insurance program, you may, in the future, be able to enroll yourself and/or your Dependents in this Plan, provided that you request enrollment within 60 days after your or your Dependents lose eligibility for that coverage.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your Dependents, provided that you request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption.

These HIPAA special enrollment rights apply to COBRA coverage, which means that you can add Dependents to your COBRA coverage upon a HIPAA special enrollment event.

B. Termination of Coverage

1. Employees

Your coverage will terminate on the earliest of the following dates:

- The last day of the month in which your employment with the MTA is terminated.
- The date the Plan is terminated by the Board of Trustees.
- The date any contribution payable by you or the MTA is not received in a timely manner in the amount required for coverage.

2. Retirees

Your coverage will terminate on the earliest of the following dates:

- The last day of the month in which you become 65 years old.
- The date the Plan is terminated by the Board of Trustees.
- The date any contribution payable by you or the MTA is not received in a timely manner in the amount required for coverage.

3. Dependents

Dependent coverage will terminate on the earliest of the following dates:

- The date the Employee's or Retiree's coverage terminates.
- The date the Plan is terminated by the Board of Trustees.
- The date Dependent coverage is terminated by the Board of Trustees.
- The date the covered individual no longer qualifies as a Dependent under the Plan.
- The date any dependent contribution payable by you is not received in a timely manner in the amount required for Dependent coverage.

4. Employee's or Retiree's Failure to Pay Participant/Dependent Contribution

If a quarterly participant/dependent contribution is not paid by the due date established by the Trust, all coverage under the Trust for you and your dependent(s), if applicable, will be terminated immediately, with one exception: medical benefits will continue to be provided to the Retiree only. Payment is considered made on the date postmarked or hand-delivered to the Administrative Office. You and your Dependents will be permitted to re-enroll for benefits at the Trust's next annual open enrollment period, provided you first pay a $150 reinstatement fee. In addition, the Trust will offset (i.e., reduce) any benefits payable to you or your Dependents by an amount equal to the unpaid quarterly contribution.

Failure to make a required contribution is not a "qualifying event" under COBRA. Therefore, you will not be entitled to elect COBRA continuation coverage if you lose Plan coverage due to a failure to pay required participant/dependent contributions.

C. Continuation of Coverage during Military Service (USERRA)

In addition to the above, if you are an Employee, your coverage, and the coverage of your Dependents if any, will terminate on the date you are absent from employment with the MTA due to service in the "uniformed services," as defined by USERRA (referred to in this section as "military service").

However, in accordance with a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Trust will provide continued coverage to Employees and their covered Dependents during periods of military service as follows.

If you are an Employee, and you are absent from covered employment due to military service, you may elect to continue Trust coverage for yourself and/or your enrolled Dependents for up to 24 months. , This USERRA coverage begins when your Trust coverage otherwise ends. For example, if the MTA continues your Trust coverage while you are on military leave, your USERRA coverage would begin after your MTA-provided coverage endsand you must pay a monthly premium for this USERRA coverage if your military service absence is longer than 30 days. ,. The monthly premium will be the same as the premium for COBRA coverage (see Article II, section E.(7) on COBRA Self Payments, page 15-16). If you are absent for 30 days or less, you will be required to pay only your normal participant contribution.

Your right to USERRA coverage may terminate early if: (1) you are discharged from military service, and you do not return or reapply for employment with the MTA within the required timeframe after your military service ends; or you do not have reemployment rights due to a less than honorable discharge from the military.

1. Selection of USERRA Coverage

You must, pursuant to MTA's Military Leave Policy, notify the MTA of your military leave of absence. The MTA will then notify the Administrative Office of your military leave and when your Trust coverage will end. The Administrative Office will mail you a USERRA election form. Unless military necessity prevents or otherwise makes your compliance impossible or unreasonable, you must elect USERRA coverage by completing and returning the USERRA election form by the same deadline applicable to electing COBRA coverage (refer to section E6). You must also pay for USERRA coverage. The amount of the payment and the payment rules for USERRA coverage are the same as the payment amount and rules that apply to COBRA coverage. As with COBRA coverage, your Dependents have an independent right to select USERRA coverage if you reject it.

You may choose to be covered under both COBRA and USERRA. There is no additional charge for dual coverage. If you are eligible for both, the maximum coverage under USERRA may be up to 6 months longer than under COBRA. Your Dependents also have the right to select coverage on their own, independent of your choice.

Please contact the Administrative Office if you have any questions about your right to USERRA coverage.

2. Employment After Military Service — Reinstatement of Benefits

If your Trust coverage terminated as a result of your military service, and you return to employment with the MTA, you will be entitled to have your Trust coverage reinstated if you satisfy USERRA's conditions for reemployment.

Please contact the Administrative Office when you return to covered employment after military service or if you have any questions about reinstatement of Trust coverage upon reemployment.

D. During a Leave of Absence

A Full Time Employee going on a personal leave of absence may continue Employee and Dependent coverage by submitting, in advance, the required monthly participant/dependent contributions to the Administrative Office for the duration of the leave. The amount to be paid is the amount the MTA would normally pay for the Employee plus, if applicable, the regular participant/dependent contribution. (Payments are due and payable in the same manner as COBRA payments, see Article II, section E.(7), paragraph C on page 15-16).

The MTA will pay the employer contribution for those Employees who are on a confirmed sick-leave, for up to 12 months. These Employees may be required to submit a report of their physical condition to the Administrative Office. Employees on sick-leave must pay, in advance, the participant/dependent contribution to maintain coverage, as applicable.

In the event of the Employee's death, the MTA will pay the employer contribution for up to 12 months for those Employee's Dependents who elect to continue their coverage under the Trust. Your Dependent must pay the participant contribution and, if there is more than one Dependent, the Dependent contribution.

The MTA may, at its discretion, pay the employer contribution for those Employees who are on a confirmed military leave of absence. (Please see Article II (C), page 7-8 on your rights to USERRA continuation coverage).

E. COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) gives you and your covered Dependents the right to temporarily extend your group health plan coverage under the Trust (called "COBRA coverage") at group rates following certain life events (called "qualifying events") that would normally end your coverage. **Please be aware that you or your Dependent(s) must pay for COBRA coverage by paying the monthly premiums directly to the Administrative Office.** This section of

the booklet is a summary of your rights and obligations regarding COBRA coverage. For more information about COBRA, contact the Administrative Office.

1. What Benefits Can Be Continued Under COBRA?

Under COBRA, you may only continue the medical, dental, vision, and wellness and hearing aid benefits that you had at the time of the qualifying event. You may not continue any other Plan benefits, such as your life insurance benefits, under COBRA.

If you elect COBRA coverage, you have two options: (1) you can choose to continue your medical benefits only; or (2) you can continue your medical, dental, vision, and wellness and hearing aid benefits. In any case, you must remain in the plan in which you were enrolled at the time of the qualifying event (i.e., indemnity or HMO). You can change plans at open enrollment.

COBRA coverage is the same Trust coverage that is provided to Participants who are not receiving COBRA. If there is a change in the coverage provided to similarly situated Trust Participants who are not on COBRA, that same change will apply to COBRA coverage. A Qualified Beneficiary who elects COBRA coverage will be given the same rights under the Trust as Participants not receiving COBRA coverage, including open enrollment and special enrollment rights.

2. What are COBRA Qualifying Events?

For an Employee

If you are an Employee, you will become a Qualified Beneficiary with the right to elect COBRA coverage for yourself if you lose Trust coverage for any of the following reasons:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Even if you do not elect COBRA coverage for yourself, each of your covered Dependents will have a separate right to elect it. **THEREFORE, IT IS IMPORTANT THAT YOU AND ALL OF YOUR DEPENDENTS READ THIS SECTION OF THE BOOKLET.**

For a Dependent Spouse

If you are a Dependent spouse, you will become a Qualified Beneficiary with the right to elect COBRA coverage for yourself if you lose Trust coverage for any of the following reasons:

- The Employee's hours of employment are reduced;

- The Employee's employment ends for any reason other than his or her gross misconduct;

- Divorce from the Employee or Retiree; or

- The death of the Employee or Retiree.

For a Dependent Child

A Dependent child will become a Qualified Beneficiary with the right to elect COBRA coverage for himself or herself if he or she loses Trust coverage for any of the following reasons:

- The Employee's hours of employment are reduced;

- The Employee's employment ends for any reason other than his or her gross misconduct;

- The child ceases being eligible for coverage as a "Dependent" as defined under this Plan; or

- The death of the Employee or Retiree.

Bankruptcy as a Qualifying Event

If a proceeding in bankruptcy is filed under title 11 of the United States Code with respect to an employer, and that bankruptcy results in the loss of Trust coverage for any Retiree, the Retiree, as well as his or her covered Dependents may be entitled to elect COBRA coverage.

3. When Does COBRA Coverage Begin?

Your COBRA coverage start date depends on the qualifying event:

- If the qualifying event is termination or reduction in hours of employment: Trust coverage will end on the last day of the month in which the qualifying event occurs, and COBRA coverage will begin on the first day of the following month.

- If the qualifying event is death: Trust coverage will end on the last day of the month for which the MTA makes its last contribution, and COBRA coverage will begin on the first day of the following month.

- If the qualifying event is divorce or the cessation of "Dependent" child status: Trust coverage will end on the last day of the month in which the divorce occurred or the child no longer met the requirements for Dependent coverage, and COBRA coverage will begin on the first day of the following month.

Example: If you and your spouse get divorced on January 15, your spouse will lose Trust coverage on January 31, and COBRA coverage for your spouse (if elected) will begin on February 1.

4. How Long Does COBRA Coverage Last?

The duration of your COBRA coverage depends on the qualifying event:

- If the qualifying event is termination or reduction in hours of employment, , the maximum COBRA coverage period is 18 months.

- For all other qualifying events, the maximum COBRA coverage period is 36 months.

There are four ways to extend an 18-month maximum COBRA coverage period, as described in detail below.

a. Disability Extension

If one COBRA enrollee in your family is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA coverage or earlier, and the disability lasts until at least the end of the initial 18-month COBRA coverage period, then all of the COBRA enrollees in your family may be entitled to receive up to an additional 11 months of COBRA coverage (at increased rates), for a maximum COBRA coverage period of 29 months.

To be eligible for this disability extension, you or your Dependent must notify the Administrative Office in writing of the SSA's determination within 60 days after the later of: (1) the date of the SSA disability determination; or (2) the date Trust coverage is lost as a result of the termination or reduction in hours of employment. In any event, notice must be provided before the end of the initial 18-month maximum COBRA coverage period. Notice is considered provided on the date it is postmarked or hand-delivered to the Administrative Office. The written notice must contain the following information: (1) the Employee's name and social security number; (2) the name(s) and social security number(s) of the Dependent(s) requesting the extension; (3) the Employee's mailing address and telephone number; (4) the mailing address(es) and telephone number(s) of the Dependent(s), if different; (5) a statement that the notice is a request for an extension of COBRA due to a disability; (6) the name of the disabled person; (7) the date the disability began; and (8) and a copy of the SSA disability determination letter.

This disability extension will end on the earliest of the following: (1) the end of the 29-month maximum COBRA coverage period; (2) 30 days after the last day of the month in which the SSA determines that the disabled person is no longer disabled (this must be reported to the Administrative Office within 30 days after the SSA makes its final determination); or (3) pursuant to the applicable termination provisions of this section specifying when COBRA coverage ends.

b. Second Qualifying Event

If, during the initial 18-month maximum COBRA coverage period, a second qualifying event occurs that is death, divorce, or the cessation of Dependent child status, the original 18-month period will be extended to 36 months for those individuals who: (1) were covered Dependents on the first qualifying event date; and (2) had COBRA coverage on the second qualifying event date, but only if the second qualifying event would have caused the Dependent(s) to lose Trust coverage had the first qualifying event not occurred**.**

In all of these cases, you or your family member must notify the Administrative Office in writing of the second qualifying event within 60 days of such event. Notice is considered provided on the date it is postmarked or hand-delivered to the Administrative Office. The written notice must contain the following information: (1) the Employee's name and social security number; (2) the name(s) and social security number(s) of the Dependent(s) requesting the extension; (3) the Employee's mailing address and telephone number; (4) the mailing address(es) and telephone number(s) of the Dependent(s), if different; (5) a statement that the notice is a request for an extension of COBRA due to a second qualifying event; (6) the date and nature of the second qualifying event; and (7) appropriate documentation in support of the second qualifying event, such as divorce documents or a birth certificate.

Example: You lose your job (the first qualifying event), and you elect COBRA coverage for yourself and your Dependent child. Three months after your COBRA coverage begins, your child turns 26 years old and is no longer eligible for Trust coverage. Your child can continue COBRA coverage for another 33 months, for a total of 36 months of COBRA coverage, provided you or another family member notifies the Administrative Office in writing within 60 days of your child's 26th birthday.

c. Termination of Employment or Reduction in Hours After MedicareEntitlement - Special Rule.

If you became entitled to Medicare within 18 months before the occurrence of a qualifying event that is your termination or reduction in hours of employment, then the maximum COBRA coverage period for your Dependents is 36 months beginning on the date you became entitled to Medicare.

d. Special Extension of COBRA coverage under California law – HMO only

COBRA enrollees enrolled in Kaiser or UnitedHealthcare may be entitled to a special extension of coverage under California law ("Cal-COBRA coverage"), for up to a total of 36 months from the date COBRA coverage first started.

Cal-COBRA coverage may be available if you and/or your Dependents:

- Began receiving COBRA coverage on or after January 1, 2003;
- Have a maximum COBRA coverage period of less than 36 months; and
- Have exhausted such COBRA coverage.

The premium payments for Cal-COBRA coverage (typically months 19 through 36) must be paid directly to Kaiser or UnitedHealthcare and will be higher than the payments for standard COBRA coverage.

This special extension only applies to the benefits provided through Kaiser or UnitedHealthcare; it does not apply to any other Trust benefits.

To elect Cal-COBRA coverage please contact Kaiser Permanente Health Plan at (800) 464-4000 or UnitedHealthcare (800) 624-8822 directly.

5. Your Responsibility to Notify the Administrative Office

The Trust will offer COBRA coverage to you and your covered Dependents only after the Administrative Office has determined that a qualifying event has occurred. The Administrative Office cannot make this determination unless is it properly notified.

When You Must Notify the Administrative Office of a Qualifying Event (Very Important Information): In order to elect COBRA coverage after a divorce or a cessation of Dependent child status, you and/or a family member **must inform the Administrative Office in writing of that event no later than 60 days after that event occurs.** Notice is considered provided on the date it is postmarked or hand-delivered to the Administrative Office. Notice should be sent to the following address:

Transportation Communications International Union -
Los Angeles County Metropolitan Transportation
Authority Health and Welfare Trust Fund
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205 City
of Industry, CA 91746-3434
(800) 427-5342

IF NOTICE IS NOT PROVIDED TO THE ADMINISTRATIVE OFFICE WITHIN THIS 60-DAY PERIOD, YOU AND YOUR DEPENDENT(S) WILL NOT BE ENTITLED TO COBRA COVERAGE.

Your employer is responsible for notifying the Administrative Office of your death, termination of employment, reduction in hours, or your employer's

commencement of a bankruptcy proceeding. However, **you or your family member should also notify the Administrative Office promptly and in writing** if any such event occurs to assure prompt handling of your COBRA rights.

6. Electing COBRA Coverage

Once the Administrative Office has determined that a qualifying event has occurred, it will send you and/or your Dependents a COBRA election form, as well as other information regarding COBRA coverage. You will have at least 60 days from the later of the date your coverage ends or the date the Administrative Office sends you the COBRA election form to make your election.

A COBRA election is considered made on the date the completed and signed COBRA election form is postmarked or hand-delivered to the Administrative Office.

Each Qualified Beneficiary will have an independent right to elect COBRA coverage. For example, an Employee's spouse may elect COBRA coverage even if the Employee does not. COBRA coverage may be elected for only one, some, or for all Dependents who are Qualified Beneficiaries. Furthermore, the Employee or his or her spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary.

If a Qualified Beneficiary rejects COBRA coverage before the end of the 60-day election period, (s)he may change his/her mind as long as a completed COBRA election form is submitted to the Administrative Office before the end of the 60-day period. If this occurs, COBRA coverage will begin on the date the completed and signed COBRA election form is submitted.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT ELECT COBRA COVERAGE WITHIN THIS 60-DAY PERIOD, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

7. Paying for COBRA Coverage

You and/or your Dependents must pay for COBRA coverage on the following basis:

- Any person with COBRA coverage must pay a monthly premium for such coverage. The amount of such premium will be established by the Board of Trustees from time to time and will be shown on the COBRA election form.

  (a) All payments must be made by check, cashier's check, or money order.

  (b) The first COBRA coverage payment must be made within 45 days after the date of your COBRA election (i.e., the date your COBRA

election form is postmarked or hand-delivered to the Administrative Office). The payment should be received, however, by the Administrative Office no later than the 20th day of the month prior to the month for which you desire coverage, in order to avoid possible delays in claim payments and eligibility problems. The first payment must cover the number of months from the date COBRA coverage began, including the month in which the first payment is made.

(c) Subsequent COBRA coverage payments must be made on a monthly basis to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. For example, if you want COBRA coverage for the month of February, payment should be received by January 20th. Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in termination of COBRA coverage as of the end of the period for which the last payment has been made.

(d) Payment is considered made on the date that it is postmarked or hand-delivered to the Administrative Office.

The Administrative Office will <u>not</u> send you monthly bills or warning notices. It is your responsibility to submit payments when due.

8. Termination of COBRA Coverage

Your COBRA coverage will end on the earliest of the following dates:

- The date the 18, 29 or 36 month maximum COBRA coverage period has been exhausted;

- The date that the Trust no longer provides group health coverage to any Participants;

- The date you fail to make a COBRA premium payment in full and on time;

- The date a Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA, unless entitlement to Medicare is for a reason other than age;

- The date a Qualified Beneficiary, after electing COBRA coverage, become covered under another group health plan ; or

- During a disability extension period, on the last day of the month after

the month in which the SSA makes a final determination that the Qualified Beneficiary is no longer disabled.

- The Trust has determined that the Qualified Beneficiary's COBRA coverage must be terminated for cause (on the same basis as would apply to similarly situated non-COBRA Trust Participants).

- The date the MTA ceases to contribute to the Trust, if the MTA provides alternate group health coverage to a class of employees formerly covered under the Trust (in which case, benefits may be continued through the MTA's new plan).

Your Duty to Notify the Administrative Office of Medicare Entitlement or Eligibility for Other Group Health Coverage AFTER Electing COBRA. If, after electing COBRA, you or your Dependent becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under another group health plan, you or your Dependent must notify the Administrative Office in writing of such event, within thirty (30) days of the Medicare entitlement date or the coverage commencement date under the other group health plan, as applicable. Notice is considered provided on the date it is postmarked or hand-delivered to the Administrative Office.

Notice of Early Termination of COBRA. The Administrative Office will notify you in writing if your COBRA coverage terminates before the end of your maximum COBRA coverage period. This notice will explain the reason COBRA terminated early, the COBRA coverage termination date, and any rights you may have under the Trust or under applicable law to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Trust determines that your COBRA coverage will terminate early.

9. Conversion Option

At the end of your maximum COBRA coverage period, you may be allowed to convert to an individual insurance policy if you are enrolled in the Kaiser or UnitedHealthcare plan at that time.

10. If You Have Any Questions About COBRA

If you have questions about your COBRA coverage, contact the Administrative Office or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

11. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administratrative

Office informed of any changes in the addresses of family members, as well as changes in marital status and the addition of new dependents. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

F. California Insurance Marketplace (California Exchange)

In addition to COBRA coverage, there may be other options for you and your family. The California Insurance Marketplace (Covered California) offers many health plans to choose from. Open enrollments will be held generally from October 15 through December 7 for coverage effective on January 1 of the following year. After open enrollment ends, you may have special enrollment rights under certain circumstances. More information is available from the Covered California website at ***www.coveredca.com.*** Also, you might be eligible for a tax credit that lowers your monthly premium if you are not eligible for coverage through the plan.

Note: If you enroll in COBRA and then drop your COBRA coverage, you can only enroll in exchange coverage during the exchange open enrollment period, and your coverage will become effective January 1 of the following year, unless you qualify for a special enrollment right.

III.

CHOICE OF PLANS

As an eligible Employee or Retiree, you may choose among three medical plans, two dental plans, and two vision plans (Part Time Employees, however, are only eligible for one vision plan). Regardless of the medical, dental, or vision plan selected, Employees and Retirees will be provided with hearing aid, wellness, life insurance, accidental death and dismemberment, and supplemental accident benefits. **Your enrolled Dependents may not enroll in a different plan than the one you have chosen for each type of benefit.**

As an alternative to enrolling in one of the Trust's plans, effective January 1, 2006, your employer will pay you $100 a month if you decline your coverage under all the benefits provided by the Trust on the grounds that you are covered as a dependent under your spouse's/Domestic Partner's other medical, dental and vision insurance.

A. Types of Benefits

1. Medical Benefits

Three options are available for medical benefits:

- The Fee-For-Service Medical Plan provided directly through the Trust. After payment of the applicable deductible, the Trust will pay a portion of covered medical charges, and you will be responsible for payment of the balance. If you choose this option, you and your enrolled Dependents will be covered under the Trust's Fee-For-Service Medical Plan for hospital and medical services and supplies. You may use any physician or hospital in the United States. However, if you use a Preferred Provider Organization (PPO) hospital or Physician, your out-of-pocket costs will be lower.
- It also includes the Mandatory Sav-Rx Prescription Drug Program. You must obtain your prescription drugs at Sav-Rx network pharmacies and use the Sav-Rx Card. **If you do not use the Sav-Rx Card at a Sav-Rx network pharmacy for obtaining your prescription drugs, your prescription drug claim will be denied. (See Article VI, page 34 for more on your Rx coverage)**
- The Fee-For-Service Medical Plan also includes an EAP benefit provided by Managed Health Network (MHN) to assist you with various mental health, substance use, or other family problems. Please see Article XIV, page 44-45.

- A prepaid medical plan provided by Kaiser Permanente. Services that are prescribed or directed by a Kaiser Permanente physician are provided either at no charge to you or at specified

co-payments. **Kaiser Permanente will provide you with a booklet describing its services and benefits.**

You must live or work within the service area of any Kaiser Permanente medical facility in order to enroll in this plan (see separate Kaiser booklet for a description of the service areas). If you enroll in this option, you and your enrolled Dependents must receive all care through Kaiser Permanente offices and hospitals.

- A prepaid medical plan provided by UnitedHealthcare. Services that are authorized by your UnitedHealthcare physician are provided either at no charge to you or at specified co-payments. **UnitedHealthcare will provide you with a booklet describing its services and benefits.**

  You must live within the service area of the facility you will be using in order to enroll in this plan (see separate UnitedHeathcare booklet for a description of the service areas). If you enroll in this option, you and your enrolled Dependents must receive all care through the participating medical group or physician you have selected.

2. Dental Benefits

Two options are available to eligible Employees and Retirees, and the enrolled Dependents of Employees and Retirees.

- The Fee-For-Service Dental Plan provided directly through the Trust. After payment of the applicable deductible, if any, the Trust will pay a portion of the covered dental charges, and you will be responsible for payment of the balance. If you choose this option, you and your enrolled Dependents will be covered under the Trust's Fee-For-Service Dental Plan for dental services and have the option to utilize both the First Dental Health Preferred Provider (PPO) & Exclusive Provider (EPO) Dental Networks. Using a First Dental Health PPO or EPO Dental Network dentist will reduce dental costs for you and also for the Trust. Please see Article VII, pages 34 to 37.

- A prepaid dental plan provided by United Concordia. Services that are authorized by your United Concordia dentist are provided either at no charge to you or at specified co-payments. **United Concordia will provide you with a booklet describing its services and benefits.**

  If you choose this option, you and your enrolled Dependents will be covered under the United Concordia prepaid dental plan for dental services and must receive all dental care

through your selected United Concordia dentist.

3. Vision Benefits

Two vision plans are provided by VSP:

- The VSP Choice Plan, which is a prepaid vision plan.
- The VSP Signature Plan, which contains a vision allowance of $200 per calendar year. For Participants enrolled in a prepaid medical plan, the cost of an eye exam is not counted towards the allowance, if an eye exam is conducted through the prepaid medical plan.
- **VSP will provide you with a booklet describing each of these plans, along with the services and benefits provided.**

Eligible Full Time Employees, Retirees, and their Dependents may enroll in either plan. Part Time Employees, however, are only eligible for the VSP Signature Plan.

VSP network providers must be used to obtain the full benefit. (See Article X, page 40. For details, please see the booklets provided by VSP.

4. Hearing Aid Benefits

The Fee-For-Service Hearing Aid Plan provided directly through the Trust is available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article VIII, page 38.)

5. Wellness Benefits

The Extra Mile Benefits Wellness Program is provided directly by the Trust and is available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article IX, page 39.)

6. Life Insurance Benefits

Life insurance benefits are provided by Prudential and is available to eligible Employees and Retirees. (Please see Article XI, page 40-41.)

7. Accidental Death & Dismemberment Benefits

Accidental death & dismemberment benefits are provided by Prudential and are available to eligible Employees and Retirees. (Please see Article XII, page 42.)

8. Supplemental Accident Benefits

Supplemental accident benefits are provided directly by the Trust and are available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article XIII, page 43.)

9. EAP Benefits

An Employee Assistance Program is provided by Managed Health Network (MHN) and is only available to Employees, Retirees, and Dependents who are enrolled in the Fee-For-Service Medical Plan. Please see Article XIV, page 44-45.

10. Payment in lieu of Coverage
When the employee or retiree withdraws, are there any benefits through the Trust?

The Trust will pay you $100 per month if you decline Trust coverage under certain circumstances. In order to qualify for this monthly payment, you must withdraw from all of the benefits provided by the Trust and submit proof that you are covered under other insurance coverage (medical, dental and vision) as a dependent spouse or domestic partner. You must furnish annual proof of such other coverage, such as a letter from your spouse's/Domestic Partner's insurer or a certificate of other coverage, to the Administrative Office. The $100 monthly payment is taxable and will be paid directly to you through MTA payroll. Please contact the Administrative Office for a copy of the election form. You will continue to receive $100 a month until:

- Your other insurance coverage ceases, and you enroll in Trust coverage; or
- Your eligibility under the Trust ends in accordance with this SPD, because, for example, your employment is terminated or you attain age 65; or
- You enroll in Trust Coverage during an annual open enrollment period or in connection with a "Change in Status Event" or "Special Enrollment Event".

B. How to Make Your Health Plan Selection

You must complete an enrollment card in which you choose your medical, dental, and vision plan and designate the beneficiary for your life and AD&D Insurance. Enrollment cards are available at the Administrative Office by calling (800) 427-5342. You may also receive an enrollment card from your union representative

during orientation. ***A completed enrollment card is essential before action can be taken on claims.***

You and your enrolled Dependents will not be eligible for benefits unless: (1) you complete an enrollment card as prescribed by the Trustees; and (2) if applicable, supply evidence of Dependent status as the Trustees may require from time to time. In the absence of such enrollment card or, if applicable, such evidence of Dependent status, benefits will not be payable.

C. What Booklets Describe My Rights under the Health Plans I have Chosen?

For coverage under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefits, all of which are provided directly through this Trust, your rights will only be determined, as applicable, by this booklet.

For coverage under the prepaid plans provided by Kaiser Permanente, UnitedHealthcare, United Concordia, VSP, Prudential, and MHN, your rights will only be determined, as applicable, by: (1) the Kaiser Permanente Group Service Agreement; (2) the UnitedHealthcare Group Master Contract; (3) the United Concordia Group Dental Service Agreement; (4) the VSP Service Agreement; (5) the Prudential Life Insurance Service Agreement; and/or (6) the MHN Service Agreement, as well as the written benefit descriptions from each of these respective insurers.

D. When To Make Your Health Plan Selection

You will be asked to select a medical, dental, and vision plan when you first become eligible for Trust benefits. All eligible Dependents must be enrolled in the same plans in which you enroll. Once you have made your selection, you may not change plans until the Trust's next annual open enrollment period, which is held in November of each year. However, if you are enrolled in a prepaid plan and move out of the service area before the next annual open enrollment period, you may change to the Trust's Fee-for-Service Medical Plan. Furthermore, if you lose eligibility before an annual open enrollment period, but reestablish eligibility at a later date, you will be able to change your plan selection at that time.

E. Summary

The following benefits are available to Employees or Retirees enrolled in the Fee-For-Service Medical Plan provided directly by the Trust:

- The Fee-For-Service Medical Plan provided directly by the Trust
- The Mandatory Sav-Rx Prescription Drug Program
- The Fee-For-Service Dental Plan provided directly by the Trust or the prepaid dental plan provided by United Concordia

- The Fee-For-Service Hearing Aid Plan provided directly by the Trust
- The vision plans provided by VSP (Part Time Employees, however, are only eligible for the VSP Signature Plan)
- The Extra Mile Benefits Wellness Program provided directly by the Trust
- The Supplemental Accident Benefit
- The life insurance benefit and AD&D benefits (for Employees and Retirees only) provided by Prudential
- The EAP program provided by MHN

The following benefits are available to Employees and Retirees enrolled in the prepaid medical plan provided by Kaiser or UnitedHealthcare:

- The prepaid medical plan provided by Kaiser or UnitedHealthcare
- The Fee-For-Service Dental Plan provided directly by the Trust or the prepaid dental plan provided by United Concordia
- Mental health and substance use benefits provided by the prepaid medical plan selected by the Employee or Retiree
- The Fee-For-Service Hearing Aid Plan provided directly by the Trust
- Vision plans provided by VSP (Part Time Employees, however, are only eligible for the VSP Signature Plan)
- The Extra Mile Benefits Wellness Program provided directly by the Trust
- The Supplemental Accident Benefit
- The life insurance benefit and AD&D benefits (for Employees and Retirees only) provided by Prudential
- The EAP program provided by MHN, excluding Kaiser enrollees

IV.

HOW TO FILE A CLAIM

A. For the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan, Supplemental Accident and the Extra Mile Benefits Wellness Program

1. Obtain a claim form from the Administrative Office.

2. File one form for each claim.

3. Complete Part I of the form, otherwise payment of your claim may be delayed.

4. Have your Physician or Dentist complete Part II of the form, attach

itemized bills, and submit to the Administrative Office at:

Transportation Communications International Union -
Los Angeles County Metropolitan Transportation Authority
Health and Welfare Trust
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

5. For claims assistance, you may write to the Administrative Office or call (562) 463-5090 or (800) 427-5342.

6. **BENEFITS SHALL BE PAID BY THE TRUST ONLY IF A CLAIM IS FILED WITHIN ONE YEAR FROM THE DATE ON WHICH COVERED EXPENSES WERE INCURRED.** The Trustees may, at their discretion, extend this one-year time limit if you can show in a manner satisfactory to the Trustees that it was not reasonably possible to file a claim in a timely manner. See also, Article XV Exclusions and Limitations, section F, #16 at page 48.

7. A claim is considered filed when it is received by the Aministrative Office or such other location as may be indicated on the claim form, provided that it is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim.

If you want the Trust to make a direct payment to the physician or the hospital, you must authorize assignment of your benefits. Payment will be made upon receipt of itemized bills and properly completed claim forms.

B. For the Prepaid Plans Provided by Kaiser Permanente, UnitedHealthcare, VSP and United Concordia

For information on filing claims, please refer to the booklets provided by these organizations.

C. For Life Insurance or Accidental Death and Dismemberment benefits

Contact the Administrative Office for a Prudential claim form and information on how to file a claim, including the proof required for payment of a claim.

D. For the EAP program provided by MNH

You must contact MHN for a referral by calling 1-800-227-1060. Benefits will only be provided upon pre-authorization by MHN.

V.

THE FEE-FOR-SERVICE MEDICAL PLAN PROVIDED DIRECTLY BY THE TRUST

Under the Fee-For-Service Medical Plan, benefits are provided for necessary care and treatment when authorized by a Physician.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

In the case of a Participant who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires the Trust to provide coverage, in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

This coverage is subject to the plan's annual deductibles and coinsurance provisions.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or insurer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a

length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Administrative Office.

A. The Preferred Provider Organization (PPO)

The Board of Trustees has contracted with a Preferred Provider Organization (PPO) to help you obtain quality health care at an affordable price. This PPO has negotiated contracts with Hospitals and Physicians who have agreed to provide medical services at pre-arranged rates.

No special enrollment is necessary, and you have the freedom of choosing the Hospital and Physician of your choice. **However, if you choose a non-PPO Hospital, you will be subject to an additional non-PPO Hospital admission deductible of $250 per admission, even if your applicable calendar year deductible has already been paid.**

You will be given lists of the Hospitals and Physicians in your area that are members of the PPO network. It is good practice to periodically call the Administrative Office to obtain an updated list of participating providers. If you have any questions about this program, please contact the Administrative Office.

B. Benefits under the Fee-For-Service Medical Plan

After the calendar year deductible is satisfied, the plan will pay the stated percentages for Covered Expenses until the Participant's out-of-pocket expenses total $1,000 during the calendar year, excluding the non-PPO Hospital admission deductible. When this $1,000 out-of-pocket limit is reached, the plan will pay 100% of allowed expenses incurred during the same calendar year by that same Participant. However, the co-payment limit provision does not apply to certain expenses.

1. Calendar Year Deductible

You are responsible for the first $50 of Covered Expenses that you incur in a calendar year. This is called your deductible. The deductible each calendar year applies separately to you and each enrolled Dependent, up to a maximum of $150 per family.

Any Covered Expenses incurred in the last three months of a year, which are applied toward the deductible, will be applied toward the deductible for the following calendar year.

2. Non-PPO Hospital Admission Deductible

You will be responsible for an additional $250 deductible per Hospital admission for Covered Expenses that you incur at a non-PPO Hospital.

Example: Assume you have paid the family calendar year deductible of $150, and in the space of six months, your child is admitted four times to a non-PPO Hospital. For each admission, you would have to pay a $250 non-PPO Hospital admission deductible (a total of $1,000), which you would not have had to pay if you had chosen a PPO Hospital.

3. Copayment Limit

The Copayment limit is $1,000 per person per calendar year, excluding the non-PPO Hospital admission deductible. This means that after any applicable calendar year deductible has been satisfied, the maximum a covered person must pay for certain Covered Expenses during a calendar year is $1,000.

C. Covered Expenses

Covered Expenses are either (1) the Contract Rates for PPO providers or (2) the Allowed Amount for non-PPO providers for the services and supplies listed below, which are certified by the attending Physician and determined by the Trust to be Medically Necessary for the care and treatment of Injury or Sickness and are not otherwise excluded under Article V, section D and Article XV, section E and section F. See pp. 31 and 47 to 48.

Example: Assume that you have not paid your calendar year deductible of $50 per person, and your surgeon charges $1,200 for a procedure, which the Trust determines has a Usual, Customary, and Reasonable charge of $1,000. As is explained below, the Trust pays for 80% of surgical services. Therefore, the Trust will pay $750 (i.e., 80% of $1,000 minus $50 for the calendar year deductible), and you will owe the surgeon the balance of $450

1. Inpatient Hospital Services

Remember, if you do not use a PPO Hospital, you will be responsible for an additional $250 non-PPO Hospital admission deductible. You may obtain a list of PPO Hospitals by calling the Administrative Office at (800) 427-5342.

If you or your Dependent is a registered bed patient in a Hospital for treatment of Injury or Sickness, the plan will pay 100% of the PPO Contract Rate or 100% of the Allowed Amount for a semi-private room and other necessary services and supplies obtained during the confinement.

2. Outpatient Hospital Services

If you or your Dependent are not confined in a Hospital as a registered bed patient but receive treatment in the outpatient department of a Hospital, the plan will pay 100% of the Contract Rate for a PPO Hospital or 80% of the Allowed Amount for non-PPO Hospital charges.

3. Surgical Services

The plan will pay 80% of the Covered Expenses for charges made by a surgeon, assistant surgeon and anesthetist.

4. Physician Visits

If you or your Dependent receives non-surgical treatment for an Injury or Sickness from a PPO Physician, the plan will pay 80% of the Contract Rate or 80% of the Allowed Amount for Covered Expenses for charges made by the non-contract Physician.

5. Physical Therapy, Acupuncture Treatment and Chiropractic Care

If you or your Dependent receive physical therapy, acupuncture treatment, or chiropractic care, the plan will pay 80% of the Contract Rate for PPO providers and 80% of the Allowed Amount for non-PPO providers.

6. Maternity Care

The plan will pay 100% of the Covered Expenses for delivery and all inpatient services incurred by you or your Dependent spouse only if using PPO providers and 80% of the Allowed Amount when using non-PPO providers. Delivery by a state certified midwife is covered. **Maternity care for Dependent children is not covered.**

7. Well Child Care

The plan will pay 80% of the Covered Expenses for charges for services rendered for well child care for enrolled Dependent children up to 6 years of age when using a PPO provider and 80% of the Allowed Amount when using non-PPO providers.

8. Physical Exam

The plan will pay 80% of the Covered Expenses for a routine physical exam and pap smear per calendar year for you or your Dependent. A physical exam is limited to an intermediate office visit,

CBC, urinalysis, and EKG (treadmill test is excluded). The amount payable when using PPO providers is 80% of the Contract Rate; when using non-PPO providers the payment is based on 80% of the Allowed Amount.

9. Skilled Nursing Facility

The plan will pay 80% of the Covered Expenses for charges incurred for Skilled Nursing Facility care if:

- You or your Dependent were hospitalized for treatment of an Sickness or Injury for at least 7 consecutive days;
- The confinement occurs within 14 days of discharge from the acute care Hospital; and/or
- The care is recommend by the attending Physician for the same Sickness or Injury

Benefits are payable for a maximum of 180 days for each condition or related cause. Charges will not be paid if any one of the three conditions above is not satisfied. The amount payable when using PPO providers is 80% of the Contract Rate; when using non-PPO providers the payment is based on 80% of the Allowed Amount.

10. Other Services and Supplies

The plan will pay 80% of the Covered Expenses for the following:
(The amount payable when using PPO providers is 80% of the Contract Rate; when using non-PPO providers the payment is based on 80% of the Allowed Amount

- Services of a Physician for Emergency visits to a Hospital and home visits;

- Home visits by therapists, if Medically Necessary;

- Treatment by a Physician, Dentist, or dental surgeon for Injuries to natural teeth and for a fractured jaw, as well as related x-rays which are required because of an accident;

- Services of a Registered Nurse;

- Services of a qualified speech therapist to restore speech loss or correct an impairment due to: (1) a congenital defect for which corrective surgery has been performed; or (2) an Injury or Sickness which results in a hearing loss, except where caused by mental, psychoneurotic or personality disorder, or a congenital defect;

- Services of a licensed physiotherapist, including tests to

diagnose, but excluding educational testing;

- Drugs and medicines requiring the prescription of a Physician and obtained at a Sav-Rx network pharmacy;
- Licensed ambulance service to the nearest Hospital where care and treatment of the Injury or Sickness can be given;
- Diagnostic x-ray and laboratory services;
- Required allergy testing;
- Artificial limbs, eyes, larynx, or surgical implants; home hemodialysis equipment; surgical dressings; casts, splints, trusses, braces, crutches; rental of wheel chairs (not to exceed the purchase price), hospital bed, or iron lung; and oxygen and the rental of equipment for its administration;
- Blood transfusions;
- Radium, radiation therapy, inhalation therapy, and sensory integration therapy;
- Modification to orthopedic shoes, excluding the cost of the shoes;
- Family planning; and
- Voluntary sterilizations.

D. Limitations and Exclusions

In addition to Article XV entitled "General Provisions, Limitations and Exclusions," and any limitations or exclusions contained in the benefit descriptions, the Fee-For-Service Medical Plan does not cover expenses incurred in connection with:

- Services or supplies not prescribed, recommended or approved by a Physician.
- Services or supplies that are not Medically Necessary for the treatment of a Sickness or Injury, unless specifically covered under the Medical Plan.
- Expenses in connection with cosmetic surgery, unless due to an accident occurring while covered, or to correct birth or congenital deformities or restorative surgery performed during or following mutilative surgery required as a result of illness or injury. This exclusion does not apply to cosmetic surgery to breast(s) following cancer surgery to same breast(s).

- Routine eye examinations, corrective lenses, or binocular therapy.

- Dental treatment other than as described under Covered Expenses.

- Nursing, speech therapy, physiotherapy, or other services rendered by yourself, your spouse, your relative, or your friend who is non-trained, unpaid, or who resides in your household.

- Health examinations (including x-rays, laboratory tests, and routine preventive immunizations), unless in connection with an Injury or Sickness or provided under the physical examination and well childcare expenses as outlined in Covered Expenses.

- Custodial care and homemaker services

- Education and vocational training.

- Expenses applied toward the satisfaction of a deductible.

- Acupuncture administered as surgery.

- Circumcision, if not performed within 30 days of birth.

- Transportation charges, unless covered under ambulance services.

- Services in connection with a transsexual surgery.

- Any service in connection with the treatment for obesity. This exclusion does not apply if you or your Dependent have/has a Body Mass Index of 40 or greater.

- Hospice care or alternate treatment programs, unless certified by a Physician and pre-authorized by the Trust.

- Routine chiropractic care that is not Medically Necessary.

- Heart, heart/lung, or liver transplants.

- Radial keratotomy or other surgery to correct visual acuity.

- Services to reverse voluntary surgically induced infertility.

- Infertility treatment programs and associated services, including drug treatments, artificial insemination, and in-vitro fertilization.

- Sicknesses or Injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during your performance of services in the military.

- Dependent child maternity and delivery charges.

- Ambulance services for transportation only to suit the patient's or Physician's convenience.

- Physical fitness programs or club memberships.

- Paramedic services when patient is not transported to a Hospital.

- Any services or supplies received as a Surrogate Mother related to becoming pregnant, pregnancy, or delivery charges, regardless of whether the Surrogate Mother is the biological parent. A child born to a Surrogate Mother will not be considered a Dependent under this Plan and will not be covered for any services, supplies or expenses. Services or supplies provided to an individual not covered by the Plan who acts as a Surrogate Mother for a Participant or Dependent. "Surrogate Mother" means a woman who agrees to become pregnant and to surrender the child to another person or persons. A woman who agrees, subsequent to becoming pregnant, to allow another person or persons to adopt the child, is not a "Surrogate Mother".

- Expenses incurred at a non-PPO Hospital when a Participant is a donor for an organ transplant, unless the recipient is also a Participant.

VI.

THE MANDATORY SAV-RX PRESCRIPTION DRUG PROGRAM

If you are enrolled in the Fee-For-Service Medical Plan, you must obtain your prescription drugs at Sav-Rx network pharmacies and use the Sav-Rx Card. **If you do not use the Sav-Rx Card at a Sav-Rx network pharmacy for obtaining your prescription drugs, your prescription drug claim will be denied.**

Using the Sav-Rx Card at Sav-Rx network pharmacies will reduce prescription drug costs to both you and the Trust.

Once you have received your prescription medication with your Sax-Rx Card at a Sav-Rx network pharmacy, you should submit your claim and receipt directly to the Administrative Office as if it were a claim under the Fee-For-Service Medical Plan.

So long as a Physician has written a prescription for the drug and the prescription is filled at a Sav-Rx network pharmacy, the Plan will pay 80% of the Usual, Customary and Reasonable charges for the drug.

Contact the Administrative Office to get a copy of the Sav-Rx Prescription Drug Program and its list of the participating pharmacies in the Sav-Rx network.

VII.

THE FEE-FOR-SERVICE DENTAL PLAN PROVIDED DIRECTLY BY THE TRUST

A. How Does the Fee-For-Service Dental Plan Work?

Once the calendar year deductible is satisfied, the plan will pay the stated percentages for Covered Expenses up to a calendar year maximum of $2,000 per person. This calendar year maximum does not apply to payments for orthodontics.

The lifetime maximum amount payable for covered orthodontic procedures rendered to each person is $2,000.

B. Calendar Year Deductible

You are responsible for the first $20 of Covered Expenses during a calendar year. This is called your deductible. The deductible each calendar year applies separately to you and each enrolled Dependent, up to a maximum of $60 per family.

Covered Expenses incurred in the last three months of a year, which are applied toward the deductible, may be applied toward the deductible for the following

calendar year. This deductible carry over does not, however, apply to the $60 family deductible.

C. Covered Services

Covered Expenses for all of the services listed below (with the exception of orthodontic) are payable at 90% of Usual, Customary, and Reasonable charges if you have been enrolled in the plan for up to 12 months, and 100% of Usual, Customary, and Reasonable charges if you have been enrolled in the plan for 12 or more months.

Using a Dentist in the First Dental Health network is voluntary; you do not have to switch from your current Dentist. But, by using a First Dental Health Dentist, you and the Trust should benefit from the reduced rates charged by First Dental Health Dentists. Dentists who participate in the First Dental Health PPO & EPO networks have agreed to lower their charges for dental procedures.

The following procedures are Covered Expenses under the Fee-For-Service Dental Plan:

- **Diagnostic**. Procedures used by Dentists to determine the required dental treatment. There is a $50 calendar year maximum for X-rays.

- **Preventive**. Services which include prophylaxis and topical application of fluoride solutions.

- **Restorative Dentistry**. The restoration of decayed, diseased, or damaged natural teeth to a satisfactory state of health, function, and esthetics. This includes in general, fillings, caps, and crowns using amalgam, synthetic porcelain, plastic, and/or bonded composite resin.

- **Endodontics**. Procedures for root canal filling and pulpal therapy.

- **Periodontics**. Procedures for the treatment of diseases of the gums and tissues supporting the teeth.

- **Prosthodontics/Prosthetics**. Artificial replacement of missing natural teeth with bridges and/or partial and complete dentures.

- **Oral Surgery**. Procedures for extractions and other oral surgery, including pre- and post-operative care.

- **Orthodontic Services.** The Fee-For-Service Dental Plan provides a separate benefit for orthodontic procedures. Orthodontic procedures are those that are associated with the straightening and realignment of the teeth. Covered Expenses are payable at 90% of Usual, Customary, and Reasonable charges if you have been enrolled in the plan for up to 24 months, and 100% of Usual, Customary, and Reasonable charges if you

have been enrolled in the plan for 24 or more months. Orthodontic procedures that last in excess of 24 months are not covered. All services are subject to the lifetime maximum of $2,000 per person. Services are deemed to be received as of the date of the banding or fitting of a retainer.

D. Limitations and Exclusions

In addition to Article XV entitled "General Limitations and Exclusions," and any limitations or exclusions contained in the benefit descriptions, the Fee-For-Service Dental Plan does not cover expenses incurred in connection with:

- Dental services to the extent they are covered by another group plan.
- Any treatment not ordered by a Dentist.
- Transportation charges.
- Expenses in connection with cosmetic procedures, including corrections for congenital malformations.
- Replacement of existing dentures, which are or can be made satisfactory.
- Replacement of lost or stolen prosthesis (fixed or removable) or their replacement within five years of their original installation, regardless of whether or not original installation occurred while covered under this plan.
- Appliances or restoration to increase vertical dimension, except for restorations used for the correction of surfaces worn down by attrition.
- The cost of gold restorations.
- Special techniques involving precision dentures for personalization or characterization.
- Periapical and/or bitewing x-rays taken on the same day whose cost exceeds the allowance for a full mouth series.
- Porcelain crowns and molars.
- Services that are not necessary and essential or those for which there is a poor prognosis.
- Spacers where spaces have closed or crowns of erupting teeth have penetrated alveolar bone.

- Procedures on primary teeth that are about to fall out.
- Removal of important teeth that can be retained with endodontics.
- Charges for orthodontia billed prior to the date bands or appliances are placed. Services in connection with orthognathic surgery.

VIII.

THE FEE-FOR-SERVICE HEARING AID PLAN PROVIDED DIRECTLY BY THE TRUST

A. How Does the Fee-For-Service Hearing Aid Plan Work?

If you or your Dependent incurs expenses for a hearing aid, which is certified by a Physician to be Medically Necessary, the Trust will pay for one hearing aid per ear every five years up to a maximum of $500 per device. This five-year period begins on the date on which the patient last incurred expenses for this benefit. There is no deductible.

B. Limitations and Exclusions

In addition to Article XV entitled "General Limitations and Exclusions," and any limitations or exclusions contained in the benefit description, the Fee-For-Service Hearing Aid Plan does not cover expenses incurred in connection with the following:

- Cleaning, repair, and maintenance of a hearing aid.
- Batteries.
- Replacement of a lost, stolen, or broken hearing aid for which payment was made under this plan.
- More than one hearing aid for each ear during a five-year period.

IX.

EXTRA MILE BENEFITS WELLNESS PROGRAM PROVIDED DIRECTLY BY THE TRUST

The Extra Mile Benefits Wellness Program, which is provided directly by the Trust, helps you stay well and prevent disease. Each eligible Employee or Retiree is allowed $500 of benefits per calendar year for him or herself and his or her eligible Dependents (i.e., $500 per family). The following are covered under this program:

- Nutritional counseling when performed by a registered dietician.

- Alternative remedies, including non-FDA approved medications, homeopathics, vitamins, and mineral supplements, so long as prescribed or recommended by a Physician in writing. Books and consultation fees will not be covered.

- Smoking cessation programs while under a Physician's care. In addition, the cost of over-the-counter smoking cessation medications/aids will be reimbursed provided an itemized receipt and proof-of-purchase seal has been submitted with your claim.

- Physical therapy and chiropractic services not covered through your medical plan.

The Trust will reimburse you directly and does not accept assignments. Simply submit your itemized bills with receipts, along with a completed Wellness Claim form requesting coverage under the Extra Mile Benefits Wellness Program. The Administrative Office will determine whether the bill should be processed under this program or under any other plan provided by the Trust.

To be considered, the services must be performed by a licensed or recognized practitioner. To determine whether a service or treatment is covered, it is recommended that you contact the Administrative Office before the expense is incurred.

X.

THE VISION PLANS PROVIDED BY VSP

Eligible Full Time Employees, Retirees, and their enrolled Dependents may choose between the VSP Choice Plan and the VSP Signature Plan.

Part Time Employees are only eligible for the VSP Signature Plan.

Contact the Administrative Office to get a copy of the VSP booklets that describe the benefits, services, and limitations of the Choice and Signature Plans. You must use a VSP network provider to obtain the maximum benefit under each plan.

XI.

LIFE INSURANCE BENEFITS INSURED BY PRUDENTIAL

A. Life Insurance Benefit Amount

If you are an Employee, a $35,000 life insurance benefit is payable to your beneficiary in the event of your death in accordance with the Prudential life insurance policy

If you are a Retiree, a $24,000 life insurance benefit is payable to your beneficiary in the event of your death in accordance with the Prudential life insurance policy.

There is no life insurance coverage for Dependents. Payment of the life insurance benefits by Prudential is subject to the conditions, limitations and exclusions stated in the Prudential policy. Contact the Administrative Office for a copy of the life insurance policy. [**substitute correct name as per the Prudential document].**

B. Beneficiary

Your beneficiary is the person(s) you choose to receive your life insurance benefits in the event of your death. In order to name a beneficiary, you must complete a beneficiary card, which is available at the Administrative Office, and return it to the Administrative Office. If you wish to change your named beneficiary, simply fill out another card.

If you do not name a beneficiary or if your named beneficiary dies before you, upon your death, your life insurance benefit will be paid to your relative(s) or estate in the following order:

1. To your spouse, if none, then

2. To your children in equal shares, if none, then

3. To your parents in equal shares, if none, then

4. To your brothers and sisters in equal shares, if none, then

5. To your executor or administrator.

Prudential may rely on a declaration by a person in any of the foregoing classes as the basis for the payment. Payment made before Prudential receives written notice of a claim by some other person is a complete discharge of Prudential's liabilities and releases Prudential and its agents from any claim for benefit or damages from any other person.

Life insurance benefits payable to a minor will be paid to the legally appointed guardian of the minor's estate. If there is no guardian, the benefits may be paid to the adult(s) who Prudential determines to have assumed the custody and main support of the minor, or as otherwise permitted under California law.

XII.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS INSURED BY PRUDENTIAL

The Accidental Death and Dismemberment (AD&D) benefit, which is a fully insured by Prudential, is payable if an Employee or Retiree incurs a "covered loss," as defined in accordance with the Prudential policy. The amount of the AD&D benefit payable by Prudential depends on the type of covered loss incurred. Contact the Administrative Office for a copy of the Prudential Policy

There is no AD&D benefit coverage for Dependents. Payment of the AD&D benefits by Prudential is subject to the conditions, limitations and exclusions stated in the Prudential policy.

XIII.

SUPPLEMENTAL ACCIDENT BENEFIT PROVIDED DIRECTLY BY THE TRUST

A. Enrolled in the Fee-For-Service Medical Plan

If you or your enrolled Dependent(s) require treatment for an accidental bodily injury, the Trust will pay 100% of the Covered Expenses for the first $350 of charges for the services listed in Section C below, provided that: (1) the expenses are incurred within 90 days after the accident; and (2) initial medical treatment is received within 72 hours after the accident. All other charges in excess of the $350 will be payable at 80% of the Usual, Customary, and Reasonable charges, except as otherwise provided for by the Trust. The annual deductible does not apply to this benefit, unless charges exceed $350.

B. Enrolled in a Prepaid Medical Plan

If you or your enrolled Dependent(s) require treatment for an accidental bodily injury, the Trust will pay 100% of the Usual, Customary, and Reasonable charges for the first $350 of expenses that you were required to pay for the services listed in Section C below, provided that: (1) the expenses are incurred within 90 days after the accident; and (2) initial medical treatment is received within 72 hours after the accident.

C. Applicable Services

1. Necessary services furnished by a Hospital for room and board and other services.

2. Medical and surgical treatment by a Physician.

3. Casts and dressings.

4. Laboratory and X-ray examinations.

XIV.

EMPLOYEE ASSISTANCE PROGRAM PROVIDED BY MANAGED HEALTH NETWORK (MHN)

D. Principal Benefits and Coverage

Under MHN's Employee Assistance Program ("EAP"), you can be assessed and referred to Participating Practitioners (as defined below) who can help you and your enrolled Dependents resolve personal problems that can affect your health, family life, abilities, and desire to excel at work. Individuals enrolled in the EAP are entitled to up to 3 Sessions without charge per incident per calendar year. The EAP benefit is not available to Kaiser enrollees.

E. What problems can an EAP handle?

The EAP can help you resolve a broad range of personal problems through assessment of issues and referral to Participating Practitioners including:

- Marriage/Family Issues
- Stress Management
- Emotional Problems
- Alcohol/Drug Dependency

F. Choice of Physicians and Practitioners

EAP services are provided by psychiatrists, psychologists, clinical social workers, marriage family therapists, masters level counselors, and other professionals who have a contract with MHN to provide EAP services ("Participating Practitioners").

If you are in need of services, MHN must pre-authorize a referral to a Participating Practitioner. You must call MHN at 1 800 227-1060 to be referred and prior authorization is always required to obtain EAP services. MHN will only refer you or your Dependent to one of its Participating Practitioners.

If you have questions regarding any of MHN's Participating Practitioners, or you would like a list of Participating Practitioners located within your geographic area, you can call MHN at 1-800-227-1060. You may also view and print a list of Participating Practitioners on MHN's website at www.MHN.com.

MHN's roster of Participating Practitioners is subject to change. Although MHN updates its website on a weekly basis so that the information includes only

practitioners currently available to service members, MHN cannot guarantee the initial or continued availability of any particular Participating Practitioner.

XV.

GENERAL PROVISIONS, LIMITATIONS, AND EXCLUSIONS FOR THE FEE-FOR-SERVICE MEDICAL PLAN, THE SUPPLEMENTAL ACCIDENT BENEFIT, THE FEE-FOR-SERVICE DENTAL PLAN, THE FEE-FOR-SERVICE HEARING AID PLAN, AND THE EXTRA MILE BENEFITS WELLNESS PROGRAM

A. Non-Assignment of Benefits

With the exception of medical benefits assigned to a Hospital or Physician, no Employee, Retiree, or Dependent shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment hereunder. Benefits hereunder shall not be subject to levy or execution or attachment or garnishment.

B. Facility of Payment

In the event the Trust determines that you or your enrolled Dependent is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event you or your enrolled Dependent has not provided the Trust with an address at which you can be located for payment, the Trust may, during your lifetime, pay any amount otherwise payable to you to your spouse or other relative, or to any other person or institution determined by the Trust to be equitably entitled thereto. In case of your death before all amounts payable have been paid, the Trust may pay any such amount to one or more of your following surviving relatives: your spouse, your child(ren), your parents, your siblings, or to your estate, as the Board of Trustees in its sole discretion may designate. Any payment made in accordance with this provision shall discharge the obligation of the Trust hereunder to the extent of such payment.

C. Doctor Examination During Pendency of Claim

The Trust, at its own expense, shall have the right and opportunity to have a Physician of its choice examine you or your Dependent when and so often as it may reasonably require during the pendency of any claim. Your failure to comply with the Trust's request could result in a denial of benefits.

D. Rights to Receive and Release Necessary Information

The Trust has the right to obtain information necessary to evaluate benefit claims and to release such information as may be necessary for such evaluation to its consultants, attorneys, or other persons or organizations.

E. Excessive Charges

If any provider of services presents claims that, in the judgment of the Board of Trustees, involve charges considered to be in excess of Usual, Customary, and Reasonable charges or treatment not considered Medically Necessary, the Board of Trustees may take either or both of the following actions:

1. The Board will consider covering future claims of such provider only if: (1) the provider files with the Trust such information as the Board may require; and (2) the provider receives authorization from the Trust prior to treating you or your Dependent.

2. The Board will refuse to recognize any assignment of benefits given to the provider and may make payment directly to you or your Dependent notwithstanding the existence of any assignment.

F. Services Excluded from Coverage

In addition to any exclusions listed in this SPD, the Trust will not cover the following services, charges, or expenses under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan and the Supplemental Accident Benefit:

1. Any services and supplies that are not, as determined by the Board of Trustees, reasonable and Medically Necessary for the diagnosis or treatment of a Sickness or Injury.

2. Conditions covered by Worker's Compensation or arising out of or in the course of any employment or self-employment.

3. Services or supplies furnished by or for the U.S. Government or any other government, unless payment is legally required

4. Any portion of expenses provided under any governmental program or law under which the individual is or could be covered.

5. Charges for services or supplies in excess of the Usual, Customary, and Reasonable charge. (Allowable Amount)

6. Services or supplies required for Injuries resulting from any form of warfare, invasion, or major civil disorder or while on active duty with the armed forces.

7. Services for Injuries resulting from engaging in the commission of a crime, unlawful act, or riot.

8. Services rendered for Injuries resulting from federally recognized natural disasters.

9. Services or supplies for which there is no charge or liability to pay.

10. Service provided by a Participant's relative or anyone who customarily lives in the individual's household.

11. Drugs and supplies that can be purchased without a Physician's prescription.

12. Vitamins or dietary supplements unless prescribed.

13. Experimental or investigative services, supplies, procedures, treatments or drugs.

14. Expenses incurred while the patient's coverage is not in effect.

15. Services in connection with bodily Injuries that are intentionally self-inflicted, unless the result of mental illness.

16. A claim filed more than one year after the date on which a covered expense was incurred.

17. Any service or supply furnished by a hospital or facility run by the federal government or other authorized agency, or at the expense of such agency or facility, except as required by law.

18. Expenses directly related to a non-covered procedure, service, treatment, supply or drug.

G. For Persons Eligible for Medi-Cal

Medi-Cal beneficiaries who have high cost medical conditions may qualify for the Health Insurance Premium Payment Program (HIPP), under which the California Department of Health Care Services pays health insurance premiums for certain persons who are losing employment and have a medical condition that requires a physician's treatment. For more information, including information on whether you qualify, contact the California Department of Health Care Services.

H. For Persons Disabled by HIV/AIDS

Eligible California residents with an HIV/AIDS diagnosis may qualify for premium payment assistance through the Office of AIDS (OA) HIPP. For information regarding eligibility requirements and how to apply, please go to:
http://www.cdph.ca.gov/programs/aids/Pages/OAHIPPForms.aspx

XVI.

COORDINATION OF BENEFITS

You or your enrolled Dependents may be covered by other group health plans, which can result in double coverage. If there is double coverage, the Trust follows a set of rules commonly referred to as coordination of benefits. These rules determine which of the two plans pays benefits first and which will pay second. The benefits provided under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, and the Fee-For-Service Hearing Aid Plan will be coordinated with those provided to you and your enrolled Dependents by any other plan or health care insurance, so that the total of the benefits you receive will not exceed 100% of the Covered Expenses you incur.

Coordination of benefits applies when you or your covered dependents have coverage under a different plan so that the total benefits available will not exceed 100% of the allowable expenses. Furthermore, when a claim is made, the primary plan pays its benefits without regard to any other plan. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

You must inform the Trust if: (1) you or your enrolled Dependents are covered by another group health plan; and/or (2) your spouse has a group health plan available through his or her employment.

Here is how the Trust determines which plan is primary.

- If the other plan does not have a COB feature, it will be primary and will pay benefits first.

- If both plans have COB features, then payment of benefits will be determined as follows:

    1. The plan covering the person as a participant is the primary plan and pays benefits first. The plan covering the person as a dependent is secondary and pays benefits second.

    2. If a dependent child is covered under both parents' plans, the plan covering the parent whose birthday falls earlier in the year pays benefits first. The plan covering the parent whose birthday falls later in the year pays benefits second. If both parents have the same birthday, the plan covering the parent longer will pay benefits first.

    3. If a child is covered under both parents' plans, but the parents are separated or divorced, the order of payment is as follows:

        (1st) The plan of the parent awarded financial responsibility by a court decree for the child's health care expenses

(2nd) The plan of the parent with custody of the child

(3rd) The plan of the stepparent married to the parent with custody of the child

(4th) The plan of the parent not having custody of the child

4. If none of the preceding rules applies in determining the order of payment, then the plan covering the patient the longest is the primary plan and all others are secondary.

5. The plan of a COBRA enrollee or Retiree will be secondary.

If you are covered as an Employee under the Trust and as a dependent under a pre-paid/HMO plan sponsored by your spouse's employer, you may receive treatment from either your own Physician/Hospital under one of the Trust's fee-for-service plans or from the pre-paid/ HMO plan Physician/Hospital. If you receive treatment through the pre-paid/HMO plan, the Trust will only reimburse you the amount of copayments paid to the pre-paid/HMO plan.

XVII.

THIRD PARTY LIABILITY

In all cases in which you or your enrolled Dependent incur any Sickness, Injury, disease, or other condition (collectively referred to in this Article as "injury") for which a third party may be liable or legally responsible, the Trust shall be reimbursed from any proceeds received by way of judgment, settlement, or otherwise in connection with, or arising out of, any claim for damages by you, your Dependent(s), your heir(s), parent(s), legal guardian(s), or other representative(s) (collectively referred to in this Article as "participant"), in an amount equal to, but not in excess of, the payments made or to be made by the Trust in connection with, or arising out of, such injury for which recovery is obtained from a third party.

The Trust shall have a lien on any and all amounts paid or to be paid by or on behalf of any such third party as a result of the exercise of any rights or recovery by the participant against such third party for any injury sustained for which the Trust has made payment. The Trust shall be entitled to reimbursement and or payment in satisfaction of its lien, even though the total amount of the participant's recovery is less than the actual loss suffered by the participant. The proceeds of any recovery obtained by a participant on account of the injury shall first be applied to satisfy the Trust's lien or other rights under this section.

The participant shall do whatever is necessary or appropriate to secure the above rights of the Trust, including the execution of any assignments, liens, Agreement to Reimburse, acknowledgments, or other documentation reasonably requested by the Trust (collectively referred to in this Article as "documentation"), notifying counsel of the Trust's lien and shall do nothing to prejudice such rights. A participant's failure to sign such documentation shall not defeat the Trust's right to reimbursement and/or any other of its rights as set forth in this Article. The participant shall hold in trust, for the benefit of the Trust, any and all amounts received from or on account of such third party. If any action or proceeding is commenced or any claim asserted against any third party for the injury sustained by or death of you or your enrolled Dependent or if any settlement agreement is made with such third party, the participant instituting such action or claim or participating in any such settlement shall promptly notify the Trust. The failure of the participant to give such notice to the Trust, to cooperate with the Trust, or to sign the Agreement to Reimburse constitutes a material breach of the contract between the participant and the Trust, and will result in the participant being personally responsible to reimburse the Trust.

Notice of the rights of the Trust, including the above mentioned lien rights, may be filed by the Trust with any person having a material interest in the existence of such rights, including, but not limited to, the court in which an action is filed, the attorney for the participant, and the third party responsible for said injury.

To the extent that the participant, or one claiming through the participant, fails at any time, as determined by the Trustees, to comply with the provisions of this

Article, or to the extent that any claim or action taken by the participant, or those claiming through the participant, seek or include a claim for future medical expenses and for which the Trustees determine that payment was made, the Trustees may, in their sole and absolute discretion, refuse to extend any benefits, including future benefits, that would otherwise be provided by the Trust for injuries that the Trustees determine arise from the same incident. All determinations referred to in this Article will be at the Trustee's sole and absolute discretion.

The Trust's reimbursement and lien rights shall be limited to the recovery by the Trust of the amounts it has paid in connection with such injury.

The Trust shall have the authority to reduce its third-party liens in consideration of costs incurred by the participant, including attorney's fees and costs of litigation incurred to procure the recovery, loss of earnings, out-of-pocket expenses, anticipated unreimbursed future medical expenses, the permanence of the injuries, and the impact of the same on future employment.

The Trust's lien shall apply to all amounts received or to be received by the injured party regardless of the source of payment, except that no lien shall apply to any amount received under any uninsured motorist or underinsured motorist coverage in any policy of insurance, provided that the injured party is a named insured in such policy.

Notwithstanding the foregoing, no reduction of any lien shall be made (whether or not the injured party or the party's attorney has been previously advised of a reduction) if:

(1) The Trust brings any suit or other legal proceeding, or becomes involved in any suit or proceedings, to enforce its lien or to recover any amount owing thereunder, or to defend against any claim arising out of the same; or

(2) In the opinion of the Board of Trustees, the injured party or the party's attorney has attempted to evade or avoid the Trust's lien. "Evade or avoid" includes, but is not limited to, the failure to advise the Trust that the injuries were caused by a third party, the failure to execute the written acknowledgment of the lien, or the failure to timely notify the Administrative Office of any recovery.

XVIII.

MEDICARE

A. Employees and Dependent Spouses Over Age 65

Employees, Retirees and their enrolled Dependents who are eligible for Medicare are covered by the Trust to the same extent as other Participants. For example: (1) you may enroll in Medicare while you are covered under the Trust as an Employee; or (2) you can be covered under the Trust as an Employee even though your spouse is eligible for Medicare due to age or disability. For Employees, Medicare may provide backup coverage for some care if the Trust does not pay the full cost. In technical terms, the Trust is "primary" for your covered medical expenses, and Medicare is "secondary." The Trust is secondary, however, for Medicare eligible Retirees and their Dependents. You are permitted to opt-out of Trust coverage entirely and have sole coverage under Medicare instead. If you would like more information, please contact the Social Security Office nearest you.

B. Reimbursement of Medicare Part B Premium

The MTA will reimburse you for a portion of the monthly Medicare Part B premium that you pay. To obtain reimbursement, you must submit to the MTA a Medicare reimbursement application, along with proof that you paid Medicare Part B premium payments. If you qualify, the MTA will make payments on a quarterly basis each January, April, July and October. Retroactive payments will be made only to the beginning of the quarterly periods described above, in which your application was received.

XIX.

CLAIMS AND APPEALS PROCEDURES

The following procedures apply if: (1) you or your enrolled Dependent (collectively referred to in this Article XVIII as "you") question your eligibility for benefits from this Trust, (2) you are submitting an initial claim for benefits under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, Extra Mile Benefits Wellness Program, Supplemental Accident Benefit or the Fee-For-Service Hearing Aid Plan; and/or (3) your claim has been denied and you want to appeal the decision. **Please note that these procedures do not apply to the benefits provided by Kaiser, UnitedHealthcare, United Concordia, VSP, Prudential or MHN's Employee Assistance Program. For information concerning their grievance, appeal, and arbitration procedures, please refer to their booklets.**

A. Initial Claim for Benefits

When you submit a claim for benefits to the Administrative Office, you will receive written notice of the action taken within 90 days of the receipt of your claim.

If an extension is required to process the claim due to special circumstances, you will receive written notice of this fact before the 90 days is over, and in no event will this extension be more than an additional 90 days beyond the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which the Trust expects to give its final decision on your claim. If you do not receive notice from the Trust within the above time limits, your claim is considered denied.

If your claim is denied, in whole or in part, the written notice will contain the following:

- The specific reason(s) for the denial;
- A specific reference to the pertinent plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to submit to the Administrative Office, as well as an explanation as to why this material or information is necessary; and
- An explanation of the Trust's appeal procedure.

B. Appeal Procedure

If you are not satisfied with the action taken on your initial claim for benefits, you may appeal to the Board of Trustees for reconsideration of the decision and must do so as a condition precedent to judicial review. The appeal must be received by

the Administrative Office within 60 days from the date you received notice of the initial benefit determination from the Administrative Office. The appeal must be in writing, should state all the reasons for disagreement with the decision, and include any additional facts regarding the claim for benefits which you wish to be made known in clear and concise terms.

A request for review that is not timely filed constitutes waiver of your right to reconsideration of the denial and need not be considered by the Board unless the delay was due to a reasonable cause. This does not, however, preclude you from establishing entitlement at a later date based on additional information and evidence that was not available to you within the 60-day period from the date of you received the denial notice.

The Board will fully and fairly review each appeal application. As part of the review procedure, you or your duly authorized representative may review pertinent documents and submit issues and comments in writing. However, you have no right to appear personally before the Board, unless it concludes that such an appearance would be of value in enabling it to perform its obligations. The Board or its designated Appeals Committee may require you (or your representative) or the Administrative Office to submit such additional facts as the Board or its Appeals Committee, in its sole discretion, deems advisable in making such a review.

The decision of the Board of Trustees must be in writing and a copy of it will be furnished to you. It must include specific reasons for the decision, as well as specific references to the pertinent Plan provisions on which the decision is based.

The Board will normally render a decision within 30 days following the quarterly Board of Trustees meeting that immediately follows receipt of the appeal application. If the Board notifies you in writing that additional time is needed, the 30-day period will be automatically extended to 60 days. If the Board fails to respond within the applicable period, the appeal application will be deemed denied.

XX.

DEFINITIONS

1. **Accident** means an unexpected happening that results in the bodily injury of a Participant. The term does not include: (1) an attempt at suicide or an intentionally self-inflicted injury, disease, or infirmity; or (2) bacterial infections, except those which occur with and through a cut or wound at the time of an Accident.
2. **Allowed Amount** means the Usual, Customary and Reasonable charges for Non-PPO Providers. The Trust determines UCR charges for Physicians and other medical providers separately from UCR charges for Non-PPO Hospitals. The Trust relies on several sources for its UCR determination and may select the lesser amount from among multiple UCR determinations for the same service or supply.

3. **Copayment** means any amount you are responsible to pay after the Trust has provided benefits. This is also called your "out-of-pocket" expense and is your portion of the cost of care. The copayment for a prepaid medical plan is the amount charged to you at the time of service. This is your portion of the cost of care.

4. **Contract Rate** means the amount the PPO has negotiated with health care providers for medical services.

5. **Covered Expenses** are the Contract Rates for PPO providers or the Allowed Amount for non-PPO providers. for the services and supplies listed under Article V, section C and Article VII, section C, which are certified by the attending Physician or Dentist and determined by the Trust to be Medically Necessary for the care and treatment of Injury or Sickness and are not otherwise excluded under Article V, section E and Article XII, section E and section F. See pp. 16-17 and 28 to 30.
6. **Dentist** means a person licensed to practice dentistry in the state in which he renders treatment. It does not include the spouse, child, sibling or parent of the Employee, Retiree, or their Dependents.

7. **Dependent** is a person described in Article I. (Eligibility Rules"), Section B ("Dependent Coverage").

8. **Drugs** means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer such prescription.

9. **Domestic Partner** means a person who has legally established a domestic partnership with an Employee or Retiree that is recognized under California state law by registering the domestic partnership with the California Secretary of the State in accordance with Division 2.5 of the California Family Code.

10. **Emergency** means a medical condition which, if not immediately treated, is likely to result in any of the following: death, permanent disability, prolonged temporary disability, or unwarranted prolongation of treatment; increased risk by requiring more complex or hazardous treatment; development of chronic illness; or inordinate physical or psychological suffering.

11. **Employee** means both Full Time Employees and Part Time Employees.

12. **Experimental or Experimental Treatment** means any procedures, devices, drugs, treatments, or medicines (or the use thereof) which is:

    - Considered to be experimental or investigational by any governmental agency or subdivision, including but not limited to the U.S. Food and Drug Administration, the U.S. Office of Health Technology Assessment, or the U.S. Health Care Financing Administration (HCFA) in its Medicare Coverage Issues Manual,; or

    - Not covered under Medicare reimbursement laws, regulations, or interpretations; or

    - Not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that:

        - The medical procedure, equipment, treatment or course of treatment, or drug or medicine is under investigation or is limited to research; or

        - The techniques are restricted to use at centers that are capable of carrying out disciplined clinical efforts and scientific studies; or

        - The procedures are not proven in an objective way to have therapeutic value or benefit; or

        - The procedure's or treatment's effectiveness is medically questionable.

13. **Full Time Employee** means an employee employed on a full time basis by the Los Angeles County Metropolitan Transportation Authority and working under the collective bargaining agreement with TCIU Lodge 1315 requiring contributions to this Trust.

14. **Hospital** means an institution operated pursuant to law which meets the following requirements:

- It is equipped with permanent facilities for diagnosis, major surgery, 24-hour continuous nursing service by registered professional nurses (R.N.), and 24-hour continuous supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields).

- It also includes a Psychiatric Health Facility as defined in Section 1250.2 of California Health and Safety Code, when service is rendered in the hospital for psychiatric or mental conditions.

- It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, a place for the aged, a place for alcoholics, or a place for drug addicts. If a unit or area of a hospital is operated for the care of convalescent patients or for rehabilitation purposes, charges incurred for confinement in such a unit or area shall not be considered charges made by a hospital nor shall such a unit or area be considered a part of the hospital.

- Hospital also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The types of procedures performed must permit discharge from the center on the same "working day."

15. **Injury** means harm, hurt, or damage inflicted to the body by an external force.

16. Services and supplies are **Medically Necessary** or provided due to **Medical Necessity** if such service or supply is determined by the Trust to be:

    - Appropriate and necessary for the symptoms, diagnosis, or treatment of the Injury or Sickness; and

    - Not experimental, educational, or investigational; and

    - Within the standards of good medical practice within the organized medical community; and

    - Not primarily for the convenience of the Participant, the Participant's Physician, or another provider; and

    - The most appropriate supply or level of service that can be safely

provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Trust may use peer review organizations, hospital review organizations, or other professional medical opinion to determine if health care services are Medically Necessary.

17. **Mental Health Disorder** is a mental or nervous condition diagnosed by a licensed mental health practitioner according to the criteria in the DSM-IV, as revised, and limited to severe impairment of the Participant's mental, emotional or behavioral functioning on a daily basis.

18. **Nurse** as used under the fee-for-service plan descriptions means a graduate registered nurse (R.N.) who does not ordinarily reside in the same household with the Participant and who is not a member of the Participant's immediate family.

19. **Part Time Employee** means an employee employed on a part time basis by the Los Angeles County Metropolitan Transportation Authority and working under the collective bargaining agreement with TCIU Lodge 1315 requiring contributions to this Trust.

20. **Participant** means an Employee, Retiree, or Dependent eligible for benefits under and enrolled in the Trust.

21. **Physician** as used under the fee-for-service plan descriptions means a doctor of medicine or doctor of osteopathy licensed to practice in the U.S. Physician shall also include a psychologist, podiatrist, chiropractor, certified acupuncturist, or optometrist who renders care or treatment within the limits set forth in the license issued to him by the applicable agency of the U.S. state in which he renders such care or treatment.

22. **Plan** means the plan of benefits provided by the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust, which is described in this Summary Plan Description..

23. **Preferred Provider Organization (PPO)** means an organization under contract with the Trust with which Hospitals, laboratory, radiology facilities, Physicians, and other providers of health care services contract to provide hospitalization and medical services to Participants at negotiated rates. It does not have to be an exclusive arrangement.

24. **Retired Employee or Retiree** means any person who, by reason of his retirement from active employment with the MTA, meets the eligibility

requirements for retirees established and amended from time to time by the Trust.

25. **Sickness** means illness or disease and includes pregnancy.

26. **Skilled Nursing Facility** means a legally operated and licensed institution that: (1) for a fee provides convalescents with room, board, 24-hour care by one or more professional nurses, and other nursing personnel needed to provide adequate medical care: and (2) is under full-time supervision of a Physician or Nurse. This term does not include institutions used primarily as rest facilities, facilities for the aged, or facilities for assistance in the withdrawal from dependency on alcohol or drugs.

27. **Substance Use Dependency** is an addictive relationship between a Participant and any drug, alcohol, or chemical substance that can be documented according to the criteria in the DSM-IV, as revised. Chemical dependency does not include addiction to or dependency on: (1) tobacco in any form; or (2) food substances in any form.

28. **Usual, Customary, and Reasonable (UCR)** means the usual charge made by a person, a group, or an entity, which renders or furnishes the services, treatments, or supplies that are covered under this Trust. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments, or supplies to persons: (1) who reside in the same area; and (2) whose Sickness is comparable in nature and severity. The term "area" means a zip code, county, or other geographic area as necessary, which constitutes a representative cross-section enabling the determination of usual charges.

XXI.

INFORMATION ABOUT THE PLAN

Name of Plan. Effective April 1, 1993, this Plan is known as the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund.

A. Plan Administrator and Sponsor. The Board of Trustees is the plan administrator of the Plan. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries.

B. Name and Address of the Board of Trustees. The Board of Trustees consists of three Union representatives, selected by the Union, and three representatives of the MTA, selected by the MTA, in accordance with the Trust Agreement that governs this Plan.

If you wish to contact the Board of Trustees, you may use the address and phone numbers below:

Board of Trustees
Transportation Communications International Union -
Los Angeles County Metropolitan Transportation Authority
Health and Welfare Trust Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434
(562) 463-5090
(800) 427-5342

The administrative functions of the Plan are performed by:

Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434
(562) 463-5090
(800) 427-5342

C. Name, Titles, and Addresses of the Trustees. As of May 2006, the Trustees of this Plan are:

Union Trustees

Jack Dinsdale
National Representative
Transportation Communications International Union
2000 Norris Road, Suite 103
Bakersfield, CA 93308-2238

Manuel Chavez (Alternate)
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

Freddie Flores (Alternate)
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

Michael Winston
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

Olivia Nelson-Richard - Chairman
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

Lavette Jones (Alternate)
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

MTA Trustees

Nalini Ahuja
Executive Director, Finance & Budget
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-24-1
Los Angeles, California 90012-2952

Gregory Kildare
Executive Director
Enterprise Risk and Safety Management
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-10-1
Los Angeles, California 90012-2952

Don Ott
Executive Director,
Employee and Labor Relations
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-14-2
Los Angeles, California 90012-2952

Richard Hunt
Service Sector General Manager
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-14-2
Los Angeles, California 90012-2952

D. Provider Contact Information

United Concordia
DHMO customer service number: (866) 357-3304
DHMO network: DHMO Concordia Plus
Address: 21700 Oxnard Street, Suite 500,
Woodland Hills CA 91367
DHMO Claims address: United Concordia Dental Claims,
P.O. Box 69422, Harrisburg, PA 17106

Prudential
Customer service number: (800) 524-0542
Address: The Prudential Insurance Company of America,
751 Broad St., Newark, NJ 07102
Customer Service address: The Prudential Insurance Company of America, Prudential Group Life Claim Division, P.O. Box 8517, Philidelphia, PA 19176

United HealthCare
Customer service number: (866) 633-2446
Address: UnitedHealthcare of California,
P.O. Box 6006, Cypress, CA 90630

Kaiser
Customer service number: (800) 464-4000
Address: Kaiser Permanente 3100 Thornton Avenue, 3rd Floor
Burbank, CA 91504

First Health
Customer Service number (800) 226-5116
Address: First Health 10260 Meanley Drive
San Diego, CA 92131

Sav-Rx
Customer Service number: (800) 228-3108
Address: Sav-Rx 224 North Park Ave.
Fremont, NE 68025

First Dental Health
Customer service number: (800) 334-7244
Address: First Dental Health,
5771 Copley Drive #101,
San Diego, CA 92111

Managed Health Network (EAP)
Customer service number: (800) 646-9923
Address: MHN 2370 Kerner Blvd.,
San Rafael, CA 94901

VSP Vision
Customer service number: (800) 877-7195

E. **IRS Identification Numbers.** The number assigned to the Plan by the Internal Revenue Service is 95-6118545. The Plan number is 503.

F. **Agent for Service of Legal Process.** The designated agent for the service of legal process is:

Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

The service of legal process may also be made upon any Plan Trustee.

G. **Collective Bargaining Agreement and Source of Contributions.** The MTA makes contributions to the Plan on behalf of all eligible Employees, Retirees and their eligible Dependents. The amount of the contribution is determined by the collective bargaining agreement between the MTA and the Union.

H. **Type of Plan.** The Plan is a welfare benefit plan that provides medical, vision, hearing aid, dental, wellness, life insurance, accidental death & dismemberment, supplemental accident, and EAP benefits to Employees, Retirees and their covered Dependents.

I. **Trust.** The Plan's assets and reserves are held in trust by the Board of Trustees (item 4 above) of the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund.

J. **Identity of Providers of Benefits.** Benefits provided under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, and the Fee-For-Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefit are self-funded and provided directly from the Plan itself. Prepaid medical benefits are provided by Kaiser Permanente and UnitedHealthcare. Prepaid dental benefits are provided

by United Concordia. Vision benefits are provided by VSP. EAP benefits are provided by MHN. Life insurance and accidental death and dismemberment benefits are provided by Prudential. The complete terms of the prepaid medical plans are set forth in the Kaiser Foundation Health Plan Group Hospital and Medical Service Agreement and the UnitedHealthcare Service Agreement. The complete terms of the prepaid dental plan are set forth in the United Concordia Service Agreement. The complete terms of the prepaid vision plan are set forth in the VSP Service Agreement. The complete terms of the EAP benefits are set forth in the MHN Service Agreement. The complete terms of the life insurance and accidental death & dismemberment benefits are set forth in the Prudential Life Insurance Service Agreement.

K. Fiscal Plan Year. The fiscal records of the Plan are kept separately for each fiscal plan year. The fiscal plan year begins on March 1 and ends on February 28 or February 29 of the following year.

L. The Plan's Requirements with Respect to Eligibility for Participation and Benefits. The Plan's eligibility requirements are specified in Article II of this SPD.

M. Circumstances Resulting in the Disqualification, Ineligibility or Denial or Loss of Benefits. Loss of eligibility for Plan benefits is described in Article II of this SPD. Plan exclusions are listed in Article XV, which is entitled "General Provisions, Limitations and Exclusions." Additional exclusions are listed at the end of the respective Articles for the Fee-For-Service Medical Plan (see Article V), the Fee-For-Service Dental Plan (see Article VI), the Fee-For-Service Hearing Aid Plan (see Article VIII), the Extra Mile Benefits Wellness Program (see Article IX), and the Supplemental Accident Benefit (see Article XIII).

N. Procedures to Follow for Filing a Claim and Appealing a Denied Claim. The Plan's procedure for filing a claim for benefits or for requesting a review of a denied claim for benefits under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefit is outlined in Article XIII of this SPD. The claims and appeals procedures for all other benefits are described in the booklets provided by Kaiser, UnitedHealthcare, United Concordia, VSP, Prudential and MHN, as applicable.

The Trustees reserve the right to amend, modify or discontinue all or part of this plan whenever, in their judgment, conditions so warrant.

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SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE PPO/Out-of-Network (OON)**	**KAISER (Network Providers Only)**	**UNITED HEALTHCARE (Network Providers Only)**
Deductible	$50 per person; $150 family maximum per calendar year; additional $250 per hospital confinement at OON	None	None
Lifetime Maximum	None	None	None
Calendar Year Maximum	None	None	None
Out-of-pocket maximum	$1,000 per person	$1,500 per person; $3,000/family	$1,000 per person; $3,000/family
Hospital Inpatient	PPO --100% of covered expenses OON-80% of Allowed	No charge	No charge

Room and Board	PPO -100% of covered expenses OON – 80% of Allowed	No charge	No charge
Intensive Care	PPO - 100% of covered expenses OON - 80% of Allowed	No charge	No charge
Miscellaneous	PPO - 100% of covered expenses OON - 80% of Allowed	No charge	No charge
Outpatient	PPO -100% of covered expenses OON - 80% of Allowed	- Facility - $5 copay No charge - physician	No charge
Surgery-	PPO - 80% of covered expenses OON - 80% of Allowed	No charge	No charge
Inpatient	80% of covered expenses OON - 80% of Allowed	No charge	No charge
Outpatient	80% of covered expenses OON - 80% of Allowed	No charge	No charge

SCHEDULE OF MEDICAL BENEFITS			
DESCRIP-TION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Physician		$5 copay	
Surgery-	PPO - 80% of covered expenses OON - 80% of Allowed	No charge	No charge
Inpatient	PPO - 80% of covered expenses OON - 80% of Allowed	No charge	No charge
Outpatient	PPO - 80% of covered expenses OON - 80% of Allowed	$5 per procedure	No charge
Hospital Visits	PPO - 80% of covered expenses OON - 80% of Allowed	No charge	No charge
Office Visits	PPO - 80% of covered expenses OON - 80% of Allowed	$5 per visit	$5 per visit
X-ray and Laboratory Service	PPO - 80% of covered expenses OON - 80% of Allowed	No charge	No charge

Physical Exams	PPO - 80% of allowable charges OON - 80% of Allowed	No charge	$5 per visit
Maternity Care	PPO – Delivery - 100% of covered expenses OON - 80% of Allowed	No charge	No charge
Well Child Care	PPO - 80% of covered expenses (up to 6 years of age) OON - 80% of Allowed	No charge	No charge

SCHEDULE OF MEDICAL BENEFITS			
DESCRIP-TION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Physical Therapy	PPO - 80% of covered expenses OON - 80% of Allowed	$5 per visit outpatient	$5 per visit
Chiropractic Services	PPO - 80% of covered expenses OON - 80% of Allowed	Not covered	Not covered
Acupuncture	PPO - 80% of covered expenses OON - 80% of Allowed	$5 per visit	Not covered

SCHEDULE OF MEDICAL BENEFITS			
DESCRIP-TION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Mental Health Disorders and Substance Use Inpatient	PPO - 100% of covered expenses OON - 80% of Allowed EAP – No charge; 3 free sessions/year	No charge	No charge
Outpatient	80% of covered expenses PPO – 80% of Covered expense OON - 80% of Allowed	$5 per individual visit; $2 per group visit	$5 per visit

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Prescripton Drugs	PPO (Sav-Rx) - 80% of reasonable and customary charges OON – Not Covered;	$5 per prescription for up to 100 days supply	$5 per prescripti on

SCHEDULE OF DENTAL BENEFITS		
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE* (First Dental Health)**	**UCCI**
Deductible	$20 per person; $60 maximum per family per calendar year	None
Calendar Year Maximum	$2,000 per person for non- orthodontic charges	None
Orthodontic Lifetime Maximum	$2,000 per person	None
	TRUST PAYS	**YOU PAY**
Diagnostic, Preventive Restorative, Prosthetic, Prosthodontics and Oral Surgery Enrolled in Plan -		
- first 12 months	90% of reasonable and customary charges	Various copayments
- 13th month and after	100% of reasonable and customary charges	Various copayments
Orthodontic** Enrolled in Plan		
- first 24 months	90% of reasonable and customary charges	$1,500 Child Ortho $2,000 Adult Ortho
- 25th month and after	100% of reasonable and customary charges	Fully Covered

*The fee-for-service First Dental Health Plan has three levels of benefits. You have the lowest out-of-pocket expense when you use the EPO dentists, the next lowest out-of-pocket expense when you use the PPO dentists and the most out-of-pocket expense when you use the out-of-network dentists. The listing of the EPO and PPO dentists are available at the website (www.firstdentalhealth.com).

** Orthodontic treatment in excess of 24 months is not covered.

SCHEDULE OF VISION BENEFITS	
DESCRIPTION OF BENEFITS	
The VSP Signature Plan	The VSP Signature Plan, provides a $200 allowance for one eye exam and a complete pair of prescription glasses or contact per calendar year. For those participants enrolled in a prepaid medical plan, the cost of the eye exam may be spared from the allowance if the eye exam is administered through the prepaid medical plan. Part Time Employees are only eligible for The Access Indemnity
The VSP Choice Plan	The following vision coverage is provided for a $10 copayment per calendar year when using a VSP network provider.
Exam(once every 12 months)	100% of allowable charges
Prescription Glasses Lenses(once every 12 months) Frames(once every 12 months) **-OR-** Contact Lens Care(once every 12 months)	100% of allowable charges 100% of allowable charges $150 maximum frame allowance; 20% off the amount over the allowance $200.00 allowance for the exam, fitting and evaluation
Glasses and Sunglasses	Average 20-25% savings on all non-covered lens options; 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last eye exam

Contacts	15% off cost of contact lens exam (fitting and evaluation)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotion price. Discounts only available from contracted facilities.
Out-of-Network Reimbursement Amounts:	Exam -up to $43.00 Single vision lenses – up to $26.00 Lined bifocal lenses – Up to $43.00 Lined trifocal lenses Up to $60.00 Frame – up to $40.00 Contacts – up to $100.00

SCHEDULE OF HEARING AID BENEFITS	
DESCRIPTION OF BENEFITS	**COVERAGE**
	TRUST PAYS
Hearing Aid	$500 per device; limited to one device per ear every 5 years

SCHEDULE OF EXTRA MILE BENEFITS	
DESCRIPTION OF BENEFITS	**COVERAGE**
	TRUST PAYS
Wellness Program	$500 per eligible member's family per calendar year