Transportation Communications International Union

Los Angeles County Metropolitan Transportation Authority

Health and Welfare Trust Fund Summary Plan Description

For Active and Retired Employees and their Dependents

August 2006

TRANSPORTATION COMMUNICATIONS INTERNATIONAL UNION -
LOS ANGELES COUNTY
METROPOLITAN TRANSPORTATION AUTHORITY
HEALTH AND WELFARE TRUST FUND
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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 which sets forth the Plan of Benefits provided by the Transportation Communications International Union – Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund.

This Summary Plan Description will advise you of several matters concerning the Transportation Communications International Union – Los Angeles Metropolitan Transportation Authority Health and Welfare Trust Fund including:

- How a participant becomes eligible for benefits under the Health and Welfare Trust Fund,
- What benefits are provided by the Health and Welfare Trust Fund,
- What is excluded from coverage,
- How to file a claim for benefits, and
- How to appeal a claim which is denied.

You are encouraged to share this Summary Plan Description with your family since they, too, have an interest in the benefits available through the Transportation Communications - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund. Because many changes have been made since the printing of the last Summary Plan Description, you are urged to familiarize yourself with the benefits available and your rights to those benefits. In the event of a conflict between this booklet 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

August 2006

TABLE OF CONTENTS

I.

IMPORTANT INFORMATION

A. Authorized Sources of Information

If you have any questions about your benefits, you may only rely upon this booklet, any supplements or amendments to this booklet, any Rules and Regulations, the Trust Agreement, and the written statements of the Trust Administrator and its authorized agents located in City of Industry, California. You may not rely on any oral statements. Furthermore, written representations made by individuals other than the Trust Administrator and its authorized agents are not authoritative sources of information. Questions as to eligibility, benefits and other matters should be submitted in writing to the Administrative Office located at 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 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 TCU Lodge 1315.

The benefits provided by the Trust through its Fee-For-Service Medical Plan are not insured by any contract of insurance, and there is no liability on 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, 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: (1) you or such person is not eligible or entitled to the benefits; or (2) if 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 interpret the Trust Agreement, this Plan of Benefits and any other Plan and to construe any facts relating to the application of the Plan(s) and its interpretation is final and conclusive.

II.

ELIGIBILITY RULES

A. Eligibility for Coverage

1. Active Employees ("Employees")

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

- You are an active employee of the Los Angeles Metropolitan Transportation Authority (MTA).
- You are covered by the terms of the collective bargaining agreement between the Transportation Communications International Union Local 1315 and the MTA.
- You pay a participant contribution, in an amount determined by the Trustees, for each month of eligibility.

The contribution to the Trust will be deducted automatically by the MTA through payroll deduction for all Active Employees.

Your eligibility may continue for up to 12 months while you are on an approved leave of absence or on an authorized sick leave, provided you timely self-pay the monthly participant contribution. .

Although not paid to you, your monthly payroll deduction counts as income and is subject to federal and state income tax. Instead of paying your participant contribution directly to the Fund, if you enroll with the Transportation Communications Union Local 1315 Flexible Benefits Plan, offered by the MTA, the Flexible Benefits Plan will transfer your monthly payroll deduction to the Fund. This will save you money because you will not have to pay income taxes on the monthly amounts transferred to the Fund.

2. 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 twenty-three (23) years of service with the MTA and/or its predecessors.

- You pay a participant contribution in an amount determined by the Trustees, for each month of eligibility. The Trust will bill you for your participant contribution, and your contribution must be received by the Trust in the same month for which you are covered.

3. Dependents of Employees and Retirees ("Dependents")

Your dependents are eligible for benefits under the Trust as "Dependents" if all of the following requirements are satisfied:

- You are an eligible Employee or Retiree.

- You elect to cover your dependents.

- You pay in each month, an amount determined by the Trustees, for dependent coverage. For Active Employees, this dependent contribution will be automatically paid to the Trust by the MTA through payroll deduction. If you are a Retiree, you must make self-payments on behalf of your dependents(s) in accordance with Plan rules.

- The person you are claiming as a dependent is:

  a. Your lawfully married spouse or Domestic Partner.

  b. Your unmarried child who is 18 years of age or younger, including:

     - Your legally adopted child or foster child or those of your spouse or Domestic Partner who permanently resides in your household and is dependent on you for financial support.

     - Your stepchild (the child of your lawfully married spouse or Domestic Partner) who permanently resides in your household.

     - A child for whom you, your spouse or Domestic Partner have been designated the court appointed legal guardian or conservator. The child must permanently reside in your household. Proof of legal guardianship or conservatorship must be submitted to the Administrative Office upon request.

  c. Your unmarried child who is a student, provided that the child is 22 years of age or younger, is attending an accredited educational, technical or trade school on a full time basis (as defined by the school), and continues to depend on you for support and maintenance. Proof of full time enrollment must be submitted to the Administrative Office each quarter or semester.

  d. Your unmarried child who became disabled before age 19, or if the child is a student (as defined in Section A.3.c., above), your unmarried child who became disabled before age 23. Under these circumstances, a child

whose coverage would otherwise terminate due to the age limits of the Plan may continue to be eligible 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 19, or if a student, 23. 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.

B. Special Rule Pertaining to Dependent Spouse Coverage

The spouse or Domestic Partner of an Employee or Retiree, who is covered under the Trust as an enrolled Dependent, will have "secondary (and not primary) coverage" under the Trust's Coordination of Benefits rules if such spouse's employer makes health care insurance available to the spouse. See Article XV, pp. 41 to 42 for an explanation of these rules.

C. Effective Date of Dependent Coverage

Once an Employee has authorized a payroll deduction for his/her existing dependents, those dependents become eligible for coverage on the same date that the Employee becomes eligible. A new dependent becomes eligible on the first of the month following the date he or she satisfies the requirements of a Dependent, provided that the dependent has been properly enrolled and payroll deductions have been authorized on the dependent's behalf. Newborns, however, are eligible as of the date of birth. **All dependents must be enrolled within 30 days of becoming a Dependent.**

D. 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 benefit programs are terminated by the Board of Trustees.
- The date any contribution payable by you or the MTA is not received in a timely manner or not 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 benefit programs are terminated by the Board of Trustees.
- The date any contribution payable by you or the MTA is not received in a timely manner or not 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 benefit programs are terminated by the Board of Trustees.
- The date Dependent coverage is terminated by the Board of Trustees.
- The date the dependent no longer qualifies as a Dependent.

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

If, after the Trust has provided you a notice of default, you fail to pay the appropriate participant/dependent monthly contribution by the first day of the month following three successive months in which you fail to pay a monthly contribution, your coverage and that of your Dependent(s) under the Trust's Dental, Vision and Wellness plans will be terminated immediately. You and your Dependents will be permitted to re-enroll in these plans at the next open enrollment provided you first pay a $150 reinstatement fee. The Trust will, in addition, offset (i.e., reduce) any benefits payable to you or your Dependents by an amount equal to the unpaid contributions.

5. In the Event of Military Service

In addition to the above, your eligibility and your Dependents' eligibility will terminate on the date on which you or your Dependent enter full-time military, naval or air service.

III.

CHOICE OF PLANS

As an eligible Employee or Retiree, you may choose among three medical plans and two dental plans. The Trust also offers vision and hearing aid benefits through its Fee-For-Service plans only. **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, the Trust will pay you $100 a month if you decline your coverage under the Trust Fund's medical, dental and vision plans on the grounds that you are covered as a dependent of your spouse's/domestic partner's other medical, dental and vision insurance.

A. Types of Benefits

1. Medical Benefits

Three options are available to eligible Employees and Retirees, and their enrolled Dependents:

- A 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; you are 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, your out-of-pocket costs will be lower.

- A Prepaid Medical Plan provided by Kaiser. 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 will provide you with a booklet describing its services and benefits.**

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

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

  You must live within the service area (see separate booklet for description of service area) of the facility you will be using in order to enroll in

this plan. 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 their enrolled Dependents:

- A 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; you are 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 may use any licensed Dentist of your choice.

- 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. Mental Health Disorders and Chemical Dependency Benefits

The Managed Mental Health and Chemical Dependency Plan provided by PacifiCare Behavioral Health is available to eligible Employees and Retirees, and their enrolled Dependents, but only if they are enrolled in the Trust's Fee-For-Service Medical Plan only. With some exceptions, Kaiser and PacifiCare also offer Mental Health Disorder and Chemical Dependency benefits.

4. Vision Benefits

A Fee-For-Service Vision Plan provided directly through the Trust is available to eligible Employees and Retirees, and their enrolled Dependents.

5. Hearing Aid Benefits

A Fee-For-Service Hearing Aid Plan provided directly through the Trust is available to eligible Employees and Retirees, and their enrolled Dependents.

6. Payment in lieu of Coverage

In order to qualify for the $100 a month payment, you must withdraw from the

Trust Fund's medical, dental and vision coverage and you must submit proof of other insurance coverage (medical, dental and vision) as a dependent spouse or domestic partner. You must furnish annual proof of other insurance dependent coverage as a dependent, such as a Notice of Creditable Coverage, a letter from your spouse's/domestic partner's insurer, or a certificate of other coverage to the Trust Fund's administrator. The $100 taxable monthly payment will be paid to you directly through MTA Payroll. Please contact the Trust Fund Administrator for a copy of the election form. You will continue to receive a $100 a month payment until either:

- Your dependent insurance ceases and you resume coverage under the Trust Fund, or
- Notwithstanding the continuation of your dependent insurance, your eligibility under the Trust Fund would otherwise have ended in accordance with the Trust Fund's Summary Plan Description, because, for example, your employment was terminated or you attained age 65, or
- You elect to re-enroll during the annual open enrollment; otherwise, you will not be permitted to re-enroll at any other time, unless you experience a "Change in Status Event" or "Special Enrollment Event". You must notify the plan administrator, and enroll yourself (and eligible dependents, if any) within 30 days of the date of the event. No re-enrollment will be permitted until you first pay any employee contributions that you owe the Trust Fund.

B. How to Make Your Health Plan Selection

As an eligible Employee or Retiree, you must complete an enrollment card in which you choose your medical and dental plan and designate the beneficiary for your Life Insurance (for Active Employees only). 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.***

Notwithstanding any other provision of this booklet, you and your enrolled Dependents will not be eligible for benefits unless you fully complete an enrollment card as prescribed by the Trustees and supply such evidence of Dependent status as the Trustees may require from time to time. In the absence of such enrollment card or such evidence of Dependent status, benefits will not be payable.

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

If you have chosen to be covered by the Fee-For-Service Medical, Dental, Hearing Aid, and Vision Plans provided directly through this Trust and/or the Managed Mental Health and Chemical Dependency Plan provided by PacifiCare Behavioral Health, your rights will only be determined, as applicable, by: (1) this booklet; and (2) the Group Master Contract relating to the Managed Mental Health and Chemical Dependency Benefit provided by PacifiCare Behavioral Health.

If, on the other hand, you have chosen to be covered by the Prepaid Plans provided by Kaiser, PacifiCare or United Concordia, your rights will only be determined, as applicable, by: (1) the Kaiser Group Service Agreement; (2) the PacifiCare Group

Master Contract; and/or (3) the United Concordia Group Dental Service Agreement.

D. When To Make Your Health Plan Selection

You will be asked to select a medical and dental plan when you first become eligible for Trust benefits. All eligible Dependents must be enrolled in the same plans. Once you have made your selection, you may not change plans until the Trust's next 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 open enrollment, you may then change to the Trust's Fee-For-Service Medical Plan. Furthermore, if you lose eligibility before an annual open enrollment period, but re-establish 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 Fee-For-Service Dental Plan provided directly by the Trust or the
- Prepaid Dental Plan provided by United Concordia
- The Managed Mental Health and Chemical Dependency Benefit provided by PacifiCare Behavioral Health
- The Fee-For-Service Hearing Aid Plan provided directly by the Trust
- The Fee-For-Service Vision Plan provided directly by the Trust
- The Extra Mile Benefits Wellness Program provided directly by the Trust
- The Supplemental Accident Benefit
- The Life Insurance Benefit (for Active Employees Only)

The following benefits are available to Employees and Retirees enrolled in the Prepaid Medical Plan provided either by Kaiser or PacifiCare:

- The Prepaid Medical Plan provided by Kaiser or PacifiCare
- The Fee-For-Service Dental Plan provided directly by the Trust or the
- Prepaid Dental Plan provided by United Concordia
- The Managed Mental Health and Chemical Dependency Benefit provided by PacifiCare Behavioral Health - for PacifiCare enrollees only
- Mental health and chemical dependency benefits provided by Kaiser – for Kaiser enrollees only
- The Fee-For-Service Hearing Aid Plan provided directly by the Trust
- The Fee-For-Service Vision Plan provided directly by the Trust
- The Extra Mile Benefits Wellness Program provided directly by the Trust
- The Supplemental Accident Benefit
- The Life Insurance Benefit (for Active Employees Only)

IV.

HOW TO FILE A CLAIM

A. For the Fee-For-Service Medical, Dental, Hearing Aid and Vision Plans

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 and attach itemized bills and forward 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 telephone (562) 463-5090 or (800) 427-5342.

6. BENEFITS SHALL BE PAID BY THE PLAN 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 the above time limit in the event you show in a manner satisfactory to the Trustees that it was not reasonably possible to file a claim in a timely manner.

7. A claim shall be considered to have been filed when it is received by the Plan at its Trust Office or such other location as may be indicated on the claim form, and if 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, PacifiCare and United Concordia and the Managed Mental Health and Chemical Dependency Plan provided by PacifiCare Behavioral Health

For information on filing claims, please refer to their booklets.

V.

THE FEE-FOR-SERVICE MEDICAL PLAN

PROVIDED DIRECTLY BY THE TRUST

For All Employees, Retirees and Dependents Enrolled in this Plan

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

A. The Preferred Provider Organization (PPO)

The Board of Trustees has contracted with a PPO provider to help you obtain quality health care at an affordable price. This PPO Provider 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 patient'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 individual, subject to the calendar year maximum of $200,000 and the lifetime maximum of $1,000,000. 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 had you chosen a PPO Hospital.

3. Co-Payment Limit

The Co-payment 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, subject to the calendar year maximum and the lifetime maximum.

4. Calendar Year Maximum

The calendar year maximum is $200,000 per person, including no more than $35,000 per person for inpatient and outpatient treatment of Mental Health Disorders and Chemical Dependency, as well as $1,500 per person for physical therapy, acupuncture and chiropractic care. This means that no more than $200,000 will be paid under the Fee-For-Service Medical Plan on account of each covered person per calendar year.

5. Lifetime Maximum

The lifetime maximum is $1,000,000 per person. This means that during a covered person's lifetime, the Plan will pay no more than $1,000,000 in benefits, even if that person continues to incur charges.

C. Covered Expenses

Covered expenses are the contract rates for PPO Providers or the Usual, Customary and Reasonable charges 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 E and Article XII, section E and section F. See pp. 16-17 and 28 to 30.

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 are 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 covered expenses 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 80% of the allowable 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 receive non-surgical treatment for an injury or sickness from a Physician, the Plan will pay 80% of the covered expenses for charges made by the Physician. This does not include Physician visits in connection with outpatient Mental Health Disorders. The benefits payable for such disorders are described separately.

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 covered expenses up to a maximum of $1,500 per person per calendar year.

6. Maternity Care

The Plan will pay 80% of the covered expenses for charges for all necessary Hospital and Physician expenses incurred by you or your Dependent spouse only. 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. This includes routine newborn care received in the Hospital up to a maximum of three days of hospitalization following delivery.

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).

9. Skilled Nursing Facility

The Plan will pay 80% of the covered expenses for charges incurred for skilled nursing facility care if: (1) you or your Dependent were hospitalized for treatment of an illness or injury for at least 7 consecutive days; (2) the confinement occurs within 14 days of discharge from the acute care Hospital; and (3) the care is recommended by the attending Physician for the same illness 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.

10. Other Services and Supplies

The Plan will pay 80% of the covered expenses for the following:

- 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 incurred while covered by the Plan;
- 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 problems, but excluding educational testing;

- Drugs and medicines requiring the prescription of a Physician;
- 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 themselves;
- Family planning;
- Voluntary sterilizations.

D. Pre-Existing Conditions

Benefits will not be provided for any condition for which treatment was received during the three-month period immediately preceding the employee's effective date of coverage under this Plan. This limitation will not apply after six months of coverage under this Plan, or upon transfer from one of the prepaid medical plans during the annual open enrollment period.

E. Limitations and Exclusions

In addition to Article XIII entitled "General 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:

1. Anything not ordered by a Physician.
2. Expenses in connection with cosmetic surgery, unless due to an accident occurring while covered. This exclusion does not apply to cosmetic surgery to breast(s) following cancer surgery to same breast(s).
3. Routine eye examinations, corrective lenses or binocular therapy.
4. Dental treatment other than as described under covered expenses.

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

6. 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 child-care expenses as outlined in covered expenses.

7. Charges for custodial care, education or training.

8. Expenses applied toward the satisfaction of a deductible.

9. Acupuncture administered as surgery.

10. Circumcision if not performed within 30 days of birth.

11. Transportation charges, unless covered under ambulance services.

12. Services in connection with a sex change operation.

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

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

15. Routine chiropractic care that is not Medically Necessary.

16. Heart, heart/lung or liver transplants.

17. Radial keratotomy or other surgery to correct visual acuity.

18. Reversals or attempted reversals of sterilizations.

19. Infertility treatment programs including drug treatments, artificial insemination, surrogate mothers and in-vitro fertilization.

20. Illnesses or injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during your performance of services in the military.

VI.

THE FEE-FOR-SERVICE DENTAL PLAN

PROVIDED DIRECTLY BY THE TRUST

For Employees, Retirees and Dependents Enrolled In This Plan

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 member of your family, 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 13 or more months.

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

2. **Preventive.** These services include prophylaxis and topical application of fluoride solutions.

3. **Restorative Dentistry.** Provides for 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.

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

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

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

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

8. **Orthodontic Services**

The Fee-For-Service Dental Plan provides a separate benefit for orthodontic procedures. Orthodontic procedures are those that are associated with straightening and realignment of the teeth. Covered expenses are payable at 90% of reasonable and customary charges if you have been enrolled in the Plan for up to 24 months, and 100% of reasonable and customary charges if you have been enrolled in the Plan for 25 or more months. All services are subject to the lifetime maximum of $2,000 per person. Services are deemed to be received as of the date of banding or fitting of retainer.

D. Limitations and Exclusions

In addition to Article XIII 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:

1. Dental services to the extent they are covered by another group plan.

2. Any treatment not ordered by a Dentist.

3. Transportation charges.

4. Expenses in connection with cosmetic procedures, including corrections for congenital malformations, unless due to an accident occurring while covered.

5. Replacement of existing dentures which are or can be made satisfactory.

6. 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.

7. Appliances or restoration to increase vertical dimension, except for restorations used for the correction of surfaces worn down by attrition.

8. The cost of gold restorations.

9. Special techniques involving precision dentures for personalization or characterization.

10. Periapical and/or bitewing x-rays taken on the same day whose cost exceeds the allowance for a full mouth series.

11. Porcelain crowns and molars.

12. Services that are not necessary and essential or those for which there is a poor prognosis.

13. Spacers where spaces have closed or crowns of erupting teeth have penetrated alveolar bone.

14. Procedures on primary teeth that are about to fall out.

15. Removal of important teeth that can be retained with endodontics.

16. Charges for orthodontia billed prior to the date bands or appliances are placed. Services in connection with orthognathic surgery.

VII.

THE MANAGED MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT PROVIDED BY PACIFICARE BEHAVIORAL HEALTH

For All Employees, Retirees and Dependents Enrolled in the Fee-For-Service Medical Plan or the PacifiCare Prepaid Medical Plan

The Trust has contracted with PacifiCare Behavioral Health to provide the Managed Mental Health and Chemical Dependency Benefit to Employees, Retirees and Dependents enrolled in either the Trust's Fee-For-Service Medical Plan or the PacifiCare Prepaid Medical Plan. This program provides initial evaluation and referral to a network of providers, as well as hospital pre-certification and utilization review.

A. How Does the Managed Mental Health and Chemical Dependency Benefit Work?

You must use the providers within the PacifiCare Behavioral Health provider network. Services that are authorized by your network provider are offered either at no charge to you or at specified co-payments. For a referral, you should contact PacifiCare Behavioral Health at (800) 992-5465.

Inpatient treatment for Mental Health Disorders will be paid at 100% of covered charges for the initial Treatment Episode. Treatment Episodes beginning within 12 months of the first Treatment Episode will be paid at 90% of covered charges. A maximum of 30 days are covered per member per calendar year. If you or your dependent undergo outpatient treatment for Mental Health Disorders through this program, your co-payments will vary depending on the number of visits attended. A maximum of 20 visits are covered per member per calendar year.

Inpatient treatment for Chemical Dependency will be paid at 100% of covered charges. A maximum of 30 days are covered per member per calendar year. Outpatient treatment for Chemical Dependency will be paid at 100% of covered charges limited to 2 Treatment Episodes per member per calendar year.

B. Calendar Year Maximum Benefit

The calendar year maximum benefit is $35,000 per member for the treatment of Mental Health Disorders and Chemical Dependency.

NOTE: ***If a patient leaves the inpatient, residential treatment or day treatment program against the medical advice of the participating provider, covered charges under the Managed Mental Health and Chemical Dependency Benefit will be paid at 70% instead of 100%. This reduction applies to the entire Treatment Episode.***

C. Summary Schedule of Benefits

The benefits for Mental Health Disorders and Chemical Dependency treatment are outlined below:

Calendar Year Deductible	None
Calendar Year Maximum	$35,000 combined inpatient and outpatient mental health/chemical dependency
Mental Health Disorders	
Inpatient	Paid at 100% of covered charges; subsequent Treatment Episodes* beginning within 12 months of the first Treatment Episode (related or unrelated to first Treatment Episode) will be paid at 90% of covered charges; limited to 30 days per calendar year
Outpatient (limited to 20 visits per calendar year) -	
Visits:	
1 - 5	No charge
6 - 10	$10 co-payment
11 - 20	$15 co-payment
Chemical Dependency	
Inpatient	Paid at 100% of covered charges; limited to 30 days per calendar year per member
Outpatient	Paid at 100% of covered charges; limited to 2 Treatment Episodes per calendar year per member

* A treatment episode is defined by PacifiCare Behavioral Health as a structured course of treatment authorized by a PacifiCare Behavioral Health clinician and for which a member has been admitted to a facility, received behavioral health services and discharged.

VIII.

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

For All Employees, Retirees and Dependents Enrolled in Either the Fee-For-Service Medical Plan or a Prepaid Medical Plan

A. How Does the Hearing Aid Plan Work?

If you or your Dependent incur expenses for a hearing aid which is certified by a Physician to be Medically Necessary, the Trust will pay for a hearing aid per ear every five years up to a maximum of $500 per device. The five year period is deemed to have begun 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 XIII 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:

1. Cleaning, repair and maintenance of a hearing aid.

2. Batteries.

3. Replacement of a lost, stolen or broken hearing aid for which payment was made under this Plan.

4. More than one hearing aid for each ear during a five year period.

IX.

EXTRA MILE BENEFITS WELLNESS PROGRAM PROVIDED DIRECTLY BY THE TRUST

For Employees, Retirees and Dependents

Prior to January 1, 1997, the Trust reimbursed you only when you were ill or had an accident. Now, under the Extra Mile Benefits Wellness Program, the Trust pays to help you stay well and prevent disease. Each eligible member is allowed $500 of benefits per calendar year for themselves and their eligible dependents. The following are covered under this Program:

- Nutritional counseling when performed by a registered dietician.

- Alternative remedies which includes non-FDA approved medications, homeopathics, vitamins and mineral supplements. 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 chiropractics not covered through your medical plan.

The Trust will reimburse you directly and will accept no assignment. All you need to do is submit your itemized bills with receipts and 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 FEE-FOR-SERVICE VISION PLAN PROVIDED DIRECTLY BY THE TRUST

For All Employees, Retirees and Dependents Enrolled in Either the Fee-For-Service Medical Plan or a Prepaid Medical Plan

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

The Plan will pay the stated percentages for covered expenses up to a calendar year maximum of $300 per Employee/Retiree, $450 per Employee/Retiree and one Dependent, or $600 per Employee/Retiree and two or more Dependents. There is no deductible.

B. Covered Services

1. **Vision Examination.** A complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

2. **Lenses.** Allowable expenses include those for single vision, bifocal, trifocal, lenticular and contact lenses and prescription sunglasses.

3. **Frames.** Allowable expenses are limited to $120 per frame.

XI.

LIFE INSURANCE BENEFITS FOR ACTIVE EMPLOYEES ONLY

A. Life Insurance Amount

If you are an Active Employee, $10,000 will be paid to your beneficiary in the event of your death.

B. Beneficiary

Your beneficiary is the person or persons who will 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 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.

The Trust may rely on a declaration by a person in any of the foregoing classes as the basis of the payment. Payment made before the Trust receives written notice of a claim by some other person is a complete discharge of the Trust's liabilities and releases the Trust 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 the Trust determines to have assumed the custody and main support of the minor, or as otherwise permitted under California law.

XII.

SUPPLEMENTAL ACCIDENT BENEFIT PROVIDED DIRECTLY BY THE TRUST

For All Employees, Retirees and Dependents

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

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

B. Enrolled in a Pre-paid Medical Plan

If you or your enrolled Dependent require treatment for an accidental bodily injury, the Trust will pay 100% of the reasonable and customary charges of 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 of the accident; and (2) initial medical treatment is received within 72 hours from the time of the accident.

C. Applicable Services

1. Necessary services furnished by a legally operated 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.

XIII.

GENERAL PROVISIONS, LIMITATIONS AND EXCLUSIONS FOR THE FEE-FOR-SERVICE MEDICAL, SUPPLEMENTAL ACCIDENT, DENTAL, HEARING AID AND VISION PLANS

A. Non-Assignment of Benefits

With the exception of medical benefits assigned to a hospital or doctor, 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 Dependent is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event you or your 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; or 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 shall have the right to obtain information necessary to evaluate benefit claims and to release such information as may be necessary to such evaluation to its consultants, attorneys, or other persons or organizations.

E. Excessive Charges

If any provider of services presents claims which, 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 as Medically Necessary, the

Board of Trustees may take either or both of the following actions:

1. The Board may require that future claims of such provider will receive consideration 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 may refuse to recognize any assignment of benefits given to the provider and may make payment directly to you or your Dependent notwithstanding any such assignment.

F. Services Excluded from Coverage

In addition to any exclusions listed in this booklet, the Trust will not cover the following services under its Fee-For-Service Medical, Supplemental Accident, Dental, Hearing Aid and Vision Plans:

1. Any services not reasonable and Medically Necessary for the diagnosis or treatment of an illness or injury.

2. Services or supplies received as a result of an accident or sickness arising out of or in the course of 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 or to the extent provided under any governmental program or law under which the individual is or could be covered.

4. The portion of a charge for services or supplies in excess of the Usual, Customary and Reasonable charge. (Allowable amount)

5. Services or supplies required for injuries resulting from an act of war or major civil disorder.

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

7. Services rendered for injuries resulting from federally recognized natural disasters.

8. Treatment for which there is no charge or requirement to pay.

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

10. Drugs and supplies which can be purchased without a Physician's prescription.

11. Vitamins or dietary supplements.

12. Services rendered in connection with Experimental procedures, drugs or devices which are not generally recognized as safe and effective by the medical community.

13. Expenses incurred prior to the commencement of coverage or subsequent to the termination of coverage.

14. Services in connection with bodily injuries which are intentionally self-inflicted.

15. A claim filed more than one year after the date on which covered expenses were incurred.

XIV.

CONTINUATION OF COVERAGE

A. During a Leave of Absence

An Employee going on a personal leave of absence may continue both Employee and Dependent coverage by submitting the required contributions for the duration of the leave in advance to the Administrative Office. The amount to be paid is the amount the MTA would normally pay for the Employee and the regular payroll deduction for Participant and Dependent coverage, if applicable.

The MTA will continue to make the employer contribution for those Employees who are on a confirmed sick-leave, for no more than 12 months. These Employees may be required to submit a report of their physical condition. Employees on sick-leave must pay, in advance, the Participant and Ddependent contribution to maintain Dependent coverage, if applicable. In the event of the Employee's death, the MTA will continue to make the employer contribution for no more than 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 election, continue to make the employer contribution for those Employees who are on a confirmed military leave of absence. (Please see XIV(C) on your rights to USERRA continuation coverage).

B. COBRA Coverage

A federal law known as "COBRA"* gives you and your covered family members the right to temporarily extend your health coverage under the Plan (called "COBRA coverage") at group rates following certain life events (called "qualifying events") that would normally end your Plan coverage. **Please be aware that you or your Dependent(s) must pay for COBRA coverage by paying the monthly premiums directly to the Trust.** This section of the booklet is a summary of your rights and obligations regarding COBRA coverage. For more information about COBRA, contact the Trust Administrator.

1. What Benefits Can Be Continued Under COBRA?

Under COBRA, you may only continue the benefits that you had at the time of the qualifying event (discussed below in section 2). You may not, however, continue your life insurance under COBRA.

* Consolidated Omnibus Budget Reconciliation Act of 1986.

If you elect COBRA coverage, you will be entitled to the same coverage that is provided to other participants covered through the Trust. This means that you are entitled to make Plan changes at the next Open Enrollment period. You do not have to show that you are insurable to obtain COBRA coverage.

2. What are COBRA Qualifying Events?

For an Employee

If you are an Employee covered by the Plan, you have the right to choose COBRA coverage for yourself if you lose your group health coverage under the Plan for any of the following reasons:

(a) Your hours of employment are reduced; or

(b) 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 the spouse of a covered Employee or Retiree, you have the right to choose COBRA coverage for yourself if you lose your health coverage under the Plan for any of the following reasons:

(c) Your spouse's hours of employment are reduced;

(d) Your spouse's employment ends for any reason other than his or her gross misconduct;

(e) Divorce from your spouse;

(f) The death of your spouse;

(g) Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

For Dependent Children

A Dependent child of a covered Employee or Retiree has the right to choose COBRA coverage for him or herself if he or she loses health coverage under the Plan for any of the following reasons:

(a) The Employee parent's hours of employment are reduced;

(b) The Employee parent's employment ends for any reason other than his or her gross misconduct;

(c) The Employee or Retiree parent becomes enrolled in Medicare (Part A, Part B, or both);

(d) The parents' divorce

(e) The child stops being eligible for coverage as a "Dependent" as defined under this Plan; or

(f) The death of the Employee or Retiree parent.

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 health coverage of any Retiree covered under the Plan, the Retiree, as well as his or her spouse, surviving spouse, and Dependent children may be entitled to COBRA coverage.

3. When Does COBRA Coverage Begin?

COBRA coverage for you and your Dependents will begin on the first of the month following your loss of coverage due to a qualifying event.

If the qualifying event is termination of employment or a reduction in hours: You and your Dependents will lose Plan coverage at the end of the month in which the qualifying event occurs and your COBRA coverage will begin on the first day of the following month.

If the qualifying event is your death and if your Dependents elect to continue their coverage under the Plan, your Dependents COBRA coverage would begin the first of the month following the month for which the MTA last makes a contribution.

If the qualifying event is a divorce, enrollment in Medicare, or the cessation of eligibility as a "Dependent": your Dependents will lose Plan coverage on the last day of the month your divorce occurred, you enrolled in Medicare or your Dependents "aged out" of coverage.

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

4. How Long Does COBRA Coverage Last?

The maximum COBRA coverage period for you and your Dependents is 36 months, unless coverage under the Plan is lost because of a termination of employment or a reduction in hours. In these instances, the maximum COBRA coverage period for you and your Dependents is 18 months. There are, however, three ways to extend this 18-month period of COBRA coverage, which are described in detail below.

(a) Disability Extension

If you or your family member elects COBRA coverage, and then is determined

by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage or earlier, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage (at increased rates), for a total maximum of 29 months.

To be eligible for this extension, you or your Dependent must notify the Plan Administrator in writing of the Social Security Administration's determination within 60 days of the date you received the determination, but before the end of the 18-month period of COBRA coverage.

This extended period of COBRA coverage for disability will end on the earliest of the following: (1) the end of the 29-month period; (2) 30 days after the last day of the month in which Social Security determines the disabled person is no longer disabled (this must be reported to the Trust Office within 30 days after its date of issuance by Social Security); (3) the date the disabled individual becomes entitled to Medicare; or (4) pursuant to the applicable termination provisions of this section specifying when COBRA coverage ends.

(b) Second Qualifying Event

If, during the initial 18-month COBRA coverage period, the former Employee or Retiree dies, becomes divorced or legally separated, or becomes enrolled in Medicare (Part A, Part B, or both), or if a covered child ceases to be a Dependent under the Plan, **the maximum COBRA coverage period for the affected spouse and/or child may be extended to 36 months from the date of the first qualifying event (i.e., termination of employment or reduction in hours). In all of these cases, you or your family member must notify the Trust Administrator of the second qualifying event within 60 days of such event.**

> **Example:** You lose your job (the first qualifying event), and you enroll yourself and your Dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 19 years old and is no longer eligible for Plan 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 Trust Administrator in writing within 60 days of your child's 19th birthday.

This extended period of COBRA coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the Employee) during the initial 18-month period of COBRA coverage.

Termination of Employment or Reduction in Hours After Medicare Entitlement - Special Rule. If you became entitled to Medicare before the occurrence of a qualifying event that is your termination of employment or reduction in hours, then your affected spouse and/or Dependent children can elect COBRA coverage for up to the longer of: (1) 18 months from the date of your termination of employment or reduction of hours; or (2) 36 months from the date

you became entitled to Medicare.

(c) Special Extension of COBRA coverage under California law

If you and/or your Dependents are enrolled in Kaiser or PacifiCare, you and/or your Dependents may be entitled to a special extension of coverage under California law, for up to a total of 36 months coverage from the date COBRA coverage first started.

This special extension may be available if you and/or your Dependents:

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

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

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

To elect this extended coverage please contact Kaiser Permanente Health Plan at (800) 464-4000 or PacifiCare Membership Services (800) 624-8822 directly in the month in which your COBRA coverage is scheduled to end.

5. Adding Dependents to Your COBRA Coverage

(a) New Spouses and Children

If, while you are enrolled in COBRA coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for those five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, you must notify the Trust Administrator in writing **within 30 days** of acquiring the new Dependent. There may be a change in your COBRA premium amount in order to cover the new Dependent.

(b) Loss of Other Group Health Plan Coverage

If, while you are enrolled in COBRA coverage, your Dependent loses coverage under another group health plan, you may enroll that Dependent for coverage for the balance of your COBRA coverage period, provided that

1. The Dependent was previously offered enrollment in the Plan but declined Plan coverage due to coverage under another group health

plan; and

2. The other coverage was (a) COBRA coverage that was exhausted or (b) other health plan coverage that was terminated due to loss of eligibility or termination of employer contributions. (Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.)

You must enroll the Dependent **within 30 days** after the termination of the other coverage. Adding a Dependent may cause an increase in the amount you must pay for COBRA coverage.

6. Your Responsibility to Notify the Trust Administrator

The Plan will offer COBRA coverage to you and your family members only after the Trust Administrator has determined that a qualifying event has occurred. The Trust Administrator cannot make this determination unless is it properly notified.

When You Must Notify the Trust Administrator of a Qualifying Event (Very Important Information): In order to elect COBRA coverage after a divorce, legal separation, or a child ceasing to be a "Dependent" under the Plan, you and/or a family member **must inform the Trust Administrator in writing of that event no later than 60 days after that event occurs.** That notice should be sent to the following address:

Transportation Communications International Union -
Los Angeles Metropolitan Transportation Authority
Administrative Office
13191 Crossroads Parkway North, Suite 205
City of Industry, CA 91746-3434

(800) 427-5342

IF SUCH A NOTICE IS NOT RECEIVED BY THE TRUST ADMINISTRATOR WITHIN THIS 60-DAY PERIOD, YOUR FAMILY MEMBER(S) WILL NOT BE ENTITLED TO CHOOSE COBRA COVERAGE.

Your Employer is responsible for notifying the Trust Administrator of your death, termination of employment, reduction in hours, or enrollment in Medicare, or your Employer's commencement of a bankruptcy proceeding. However, **you or your family member should also notify the Trust Administrator promptly and in writing** if any such event occurs to assure prompt handling of your COBRA rights.

7. Deadline to Elect COBRA Coverage

Once the Trust Administrator has determined that a qualifying event has occurred, you and/or your family members will be sent a COBRA election form, as well as

other information regarding COBRA coverage. You will have at least sixty (60) days from the date your coverage ends or, if later, sixty (60) days from the date the Trust Administrator sends you the COBRA election form, to make your decision.

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.

8. Paying for COBRA Coverage

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

(a) 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 furnished to the eligible person with the COBRA election form.

(b) All payments must be made by check, cashiers check, or money order.

(c) The first COBRA coverage payment should be received by the Trust Administrator 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. However, this initial payment will be accepted if received within 45 days from the date you mail the form electing COBRA coverage. 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.

(d) After the first COBRA coverage payment is made, additional payments must be made every month to keep 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 thirty (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.

The Trust Administrator will not send you monthly bills or warning notices. It is your responsibility to submit payments when due.

9. Termination of COBRA Coverage

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

(a) The date the maximum 18, 29 or 36 month COBRA coverage period has been reached as described previously;

(b) The date that the Trust (or the MTA) no longer provides group health coverage to any of its Employees;

(c) The date you fail to make a timely premium payment for your COBRA coverage;

(d) The date you become entitled to receive Medicare, unless entitlement to Medicare is for a reason other than age;

(e) The date you become covered under another group health plan as an employee, spouse or dependent of an employee, unless that plan contains a provision that limits coverage for a pre-existing condition that you have. In this case, COBRA coverage will not end until the date the condition is covered under the new plan or the maximum time allowed under COBRA coverage is reached, whichever happens first; or

(f) In the case of total disability, at the end of the month after the month in which Social Security determines that the disability no longer exists.

10. Conversion Option

At the end of the 18-, 29-, or 36-month maximum COBRA coverage period, you may be allowed to convert to an individual insurance policy if you are enrolled in the Kaiser or PacifiCare plan at that time.

11. If You Have Any Questions About COBRA

If you have questions about your COBRA coverage, you should contact the Trust Administrator or you may contact 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.

12. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Trust Administrator 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 Trust Administrator.

C. Continuation of Coverage During Military Service (USERRA)

In accordance with federal law, the Plan provides continuation coverage for service members and their families during periods of service in the armed forces of the United States. If you are absent from covered employment due to military service, you may elect to continue health plan coverage for yourself and/or your

dependents for up to 24 months as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your USERRA continuation coverage begins when your coverage under the Plan otherwise ends. For example, if the MTA continues your coverage under the Plan while you are on military leave, your USERRA coverage would begin when your MTA provided coverage ended. If you are absent longer than 30 days, you must pay a monthly premium for this coverage. The monthly premium will be the same as the premium for COBRA coverage (see section on COBRA Self Payments, page 37). If you are absent from work for 30 days or less you will be required to pay only your normal participant contribution .

Your right to continuation coverage may terminate early if you are discharged from military service and you do not return or reapply for work within the required timeframe after your military service ends. Your right to continuation coverage could also terminate early if 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 notify the Trust of your military leave and when your coverage under the Plan ends. The Trust will mail you a USERRA election form. Unless military necessity prevents or otherwise makes your compliance impossible or unreasonable, you will have to elect USERRA coverage by completing and returning the USERRA election form within the same deadlines as applicable under COBRA (see Article XIV, § 7, pp. 36-37). You must also pay for such coverage and your dependents must pay in the same way and same amount as is charged under COBRA (see Article XIV, § 8, p. 37). As with COBRA, 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 Trust Administrator if you have any questions about your rights to continuation coverage under USERRA.

2. Employment After Military Service — Reinstatement of Benefits

If your coverage under this Plan terminated as a result of your service in the Armed Forces of the United States and you return to work for the MTA you will be entitled to have your coverage under this Plan reinstated if you satisfy USERRA's conditions for reemployment.

Please contact the Trust Administrator when you return to Covered Employment after serving in the military or if you have any questions about reinstatement of coverage upon reemployment.

D. 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) provided they:

1. Have a Medi-Cal share-of-cost of $200.00 or less.

2. Have a high cost medical condition for which the average monthly cost is twice the amount of the monthly health insurance premium.

3. Have current health insurance coverage, or a COBRA continuation or a conversion policy in effect or available.

4. Have filed an application with the California Department of Health Services in a timely manner, allowing sufficient time to process the application and start payment of premium.

You do not qualify if:

1. Your insurance policy is issued through the Major Risk Medical Insurance Program (MRMIP).

2. You qualify for Medicare.

3. You are enrolled in a Medi-Cal related pre-paid health plan, or a County Medical Service Program.

E. For Persons Disabled by HIV/AIDS

Under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, persons unable to work because of disability due to HIV/AIDS and who are losing their private health insurance may qualify for the Health Insurance Continuation Program provided they:

1. Are currently covered by a health insurance plan, which includes coverage for outpatient drug prescriptions, and then can be converted to a COBRA/OBRA plan.

2. Have a total monthly income below 250 percent of poverty. The poverty level varies by age and family size. You are urged to contact your local Social Security office for this information.

XV.

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 Fee-For-Service Medical, Dental, Vision and Hearing Aid Plans 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. You must inform the Trust if you or your Dependents are covered by another group health plan or if your spouse has a plan available to her or him at work.

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 participant or Retired Participant will be secondary.

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

XVI.

THIRD PARTY LIABILITY

In all cases in which you or your enrolled Dependent incur any sickness, injury, disease or other condition (hereinafter "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, your heirs, parents, legal guardians or other representative (referred to collectively 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 ("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 V. 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 the Participant or if any settlement agreement is made with such third party, the Participant or his or her representative or heir 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 Plan 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 him fails at any time, as determined by the Trustees, to comply with the provisions of this section, or to the extent that any claim or action taken by the participant or those claiming

through him, 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 injury or illness that the Trustees determine arise from the same incident. All determinations referred to in this section 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 attorneys 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:

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

In the opinion of the Board, 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.

XVII.

MEDICARE

A. Employees and Spouses Over Age 65

Employees, Retirees and their Dependents who are eligible for Medicare are covered by the Trust to the same extent as other participants. For example, you may be eligible for Medicare and you may also be eligible as an Active Employee, or you may be eligible as an Active Employee and your spouse is eligible for Medicare, because he or she is older than 65 or disabled. Medicare may provide backup coverage for some care if Trust benefits do not pay the full cost. In technical terms, the Trust is "primary" for your covered hospital and medical expenses, and Medicare is "secondary." You have, however, as required by Government regulations, the option to opt-out of the Trusts coverage entirely and enroll in Medicare instead. If you would like more information, please contact the Social Security Office nearest you. The Trust is secondary on retired Medicare eligible Employees and/or Dependents.

B. Reimbursement of Medicare Part B Premium

A portion of the monthly cost of Part B of Medicare will be reimbursed upon application to the Los Angeles County Metropolitan Transportation Authority and submission of proof of premium payment for part B of Medicare. Payments are made on a quarterly basis each January, April, July and October for the current quarter. Retroactive payments will be made only to the beginning of the quarterly periods described above, in which the Medicare Reimbursement Application was received.

XVIII.

CLAIMS AND APPEALS PROCEDURES

The following procedures apply if: (1) you or your enrolled Dependent question (collectively referred to as "you") your eligibility for benefits from this Trust, (2) you are submitting an initial claim for benefits under the Fee-For-Service Medical, Dental, Vision or Hearing Aid Plans; 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 Kaiser, PacifiCare, United Concordia or PacifiCare Behavioral Health Plans. 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 or reasons for the denial;
- A specific reference to the pertinent Plan provisions 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 Plan'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 benefit determination from the Administrative Office. The appeal must be in writing and should state all the reasons for disagreement with the decision and any additional facts regarding the claim for benefits which you wish to be made

known in clear and concise terms.

A request for review which 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 which was not available to you within such sixty (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 but 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 Administrator 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 which 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.

XIX.

DEFINITIONS

1. **Active Employee or Employee** means any person who, by reason of his employment, has earnings in the current month and otherwise meets the eligibility requirements established and amended from time to time by the Trust.

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

3. **Co-payment** 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 Co-payment 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 Usual, Customary and Reasonable charges for non-PPO providers.

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 or 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 by the State of California in accordance with California Family Code Section 297 by registering the Domestic Partnership with the Secretary of the State of California or Family Code Section 299.2. A Domestic Partnership may be formed between same-sex partners or opposite-sex partners where at least one partner is age 62 or older and meets certain eligibility criteria under the Social Security Act.

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

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

    (b) Not covered under Medicare reimbursement laws, regulations or interpretations; or

    (c) 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 which 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.

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

    (a) It is equipped with permanent facilities for diagnosis, major surgery, and 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.

    (b) 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".

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

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

    (a) Appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness; and

    (b) Not experimental, educational, or investigational; and

    (c) Within the standards of good medical practice of within the organized medical community; and

    (d) Not primarily for the convenience of the participant, the participant's Physician or another provider; and

    (e) The most appropriate supply or level of service which 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.

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

16. **Nurse** as used under the Fee-For-Service plan descriptions means a graduate registered nurse who does not ordinarily reside in the same household with the participant and who is not a member of the participant's immediate family.

17. **Physician** as used under the Fee-For-Service plan descriptions means a licensed Doctor of Medicine or Doctor of Osteopathy. 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 state in which he renders such care or treatment.

18. **Plan** means this booklet entitled the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Summary Plan Description. Depending upon the context, the term "Plan" may also be used to refer to a description of certain types of benefits provided through this Trust, such as the Fee-for-Service Medical Plan, or the Vision Plan.

19. **Preferred Provider Organization (PPO)** means an organization under contract with the Trust through which Hospitals, Laboratory and Radiology Facilities, Physicians and other providers of health care services contract to provide hospitalization and medical services to Participants payable on the basis of negotiated rates. It does not have to be an exclusive arrangement.

20. **Retired Employee or Retiree** means any person who, by reason of his retirement, meets the eligibility requirements established and amended from time to time by the Trust.

21. **Sickness** means illness or disease excluding a Mental Health Disorder. Pregnancy is considered a sickness.

22. **Skilled Nursing Facility** means a legally operated and licensed institution that (1) for a fee provides convalescents with room, board and 24 hour care by 1 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 registered 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.

23. **Treatment Episode**, as defined by PacifiCare Behavioral Health, means a structured course of treatment authorized by a PacifiCare Behavioral Health clinician and for which a member has been admitted to a facility, received behavioral health services and discharged.

24. **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 illness is comparable in nature and severity. The term "area" means a zip code, county or other geographic area that is necessary to obtain a representative cross section of the usual charges made.

XX.

INFORMATION ABOUT THE PLAN

A. 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.

B. Plan Administrator and Sponsor. The Board of Trustees is the Plan Administrator. 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.

C. 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 which 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
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

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

Union Trustees

Joel Parker -
International Vice President
Transportation Communications International Union
3 Research Place
Rockville, MD 20850

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

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

Michael Winston (Alternate)
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

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

MTA Trustees

Mr. Terry Matsumoto
Executive Officer, Finance & Treasurer
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-21-5
Los Angeles, California 90012-2952

Ms. Brenda Diederichs
Executive Officer of Labor Relations
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-14-2
Los Angeles, California 90012-2952

Ms. Carolyn Flowers
Executive Officer of Operations
Metropolitan Transportation Authority
One Gateway Plaza, 25th Floor
Los Angeles, California 90012-2952

Mr. Richard Hunt (Alternate)
Deputy Executive Officer, Operations
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 30-2-1
Los Angeles, California 90012-2952

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 a Plan Trustee.

G. Collective Bargaining Agreement and Source of Contributions. Contributions to the Plan are made 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 Los Angeles Metropolitan Transportation Authority and the Transportation Communications International Union Lodge 1315.

H. Type of Plan. This is a Welfare Plan which provides hospital, surgical, medical, vision, hearing aid and dental benefits for Employees, Retirees and their covered Dependents.

I. Trust. The Trust'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.

J. Identity of Providers of Benefits. Fee-For-Service Hospital/Medical Benefits, Dental Benefits, Hearing Aid Benefits and Vision Benefits are provided directly from the Plan itself. Prepaid Medical benefits are provided by Kaiser Permanente and PacifiCare. Prepaid Dental benefits are provided by United Concordia Dental Plans. Managed Mental Health and Chemical Dependency benefits are provided by PacifiCare Behavioral Health. 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 PacifiCare Service Agreement. The complete terms of the Prepaid Dental Plan are set forth in the United Concordia Service Agreement. The complete terms of the Managed Mental Health and Chemical Dependency Benefit are set forth in the PacifiCare Behavioral Health Master Contract.

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 eligibility requirements are specified in Article II. of this booklet.

M. Circumstances Resulting in the Disqualification, Ineligibility or Denial or Loss of Benefits. Loss of eligibility is described in Article II. of this booklet. In addition to the exclusions listed in Article XIII. entitled "General Provisions, Limitations and Exclusions", additional exclusions are described at the end of the respective Articles on the Fee-For-Service Medical Plan (see Article V.), the Fee-For-Service Dental Plan (see Article VI.) and the Fee-For-Service Hearing Aid Plan (see Article VIII.).

N. Procedures to Follow for Filing a Claim. The procedure to be followed in filing a claim for benefits is outlined in Article IV. of this booklet. All claims for benefits must be submitted on claim forms made available by the Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

O. Claims Review Procedure. The procedure to be followed in appealing a claim for benefits which have been denied in whole or in part is stated in

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

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**PACIFICARE**
Deductible	$50 per person; $150 family maximum per calendar year; additional $250 per hospital confinement at non-PPO hospital	None	None
Lifetime Maximum	$1,000,000 per person	None	None
Calendar Year Maximum	$200,000 per person; $1,500 per person for physical therapy, acupuncture and chiropractic services; $35,000 per person for mental health disorders and chemical dependency (inpatient and outpatient)	None	None
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Hospital Services			
Inpatient	100% of covered expenses	No charge	No charge
Room and Board	100% of covered expenses	No charge	No charge
Intensive Care	100% of covered expenses	No charge	No charge
Miscellaneous	100% of covered expenses	No charge	No charge
Outpatient	80% of covered expenses	No charge	No charge

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**PACIFICARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Physician	80% of covered expenses	No charge	No charge
Surgery-			
Inpatient	80% of covered expenses	No charge	No charge
Outpatient	80% of covered expenses	No charge	No charge
Hospital Visits	80% of covered expenses	No charge	No charge
Office Visits	80% of covered expenses	No charge	No charge
X-ray and Laboratory Service	80% of covered expenses	No charge	No charge (with office visit)
Physical Exams	80% of allowable charges	No charge	No charge
Maternity Care	80% of covered expenses	No charge	No charge
Well Child Care	80% of covered expenses (up to 6 years of age)	No charge	No charge (up to 2 years of age)

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**PACIFICARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Physical Therapy	80% of covered expenses Maximum of $1,500 per person per calendar year	No charge	Inpatient - no charge; Out-patient - no charge; limited to 60 consecutive calendar days of short-term care
Chiropractic Services	80% of covered expenses Maximum of $1,500 per person per calendar year	Not covered	Not covered
Acupuncture	80% of covered expenses Maximum of $1,500 per person per calendar year	Not covered	Not covered

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**PACIFICARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Mental Health Disorders Inpatient	100% of covered expenses; subsequent treatment episodes*, beginning within 12 months of the first treatment episode (related or un-related to first treatment episode) will be paid at 90% of covered charges; limited to 30 days per calendar year	No charge; limited to 45 days of hospital care per calendar year	100% of covered charges; subsequent treatment episodes* beginning within 12 months of the first treatment episode (related or unrelated to first treatment episode) will be paid at 90% of covered charges; limited to 30 days per calendar year
Outpatient	Visits: 1 - 5 No Charge 6 - 10 $10 copay 11 - 20 $15 copay	No charge; limited to 20 visits per calendar year; $5 for each additional visit	Visits: 1 - 5 No Charge 6 - 10 $10 copay 11 - 20 $15 copay

* A treatment episode is defined by PacifiCare Behavioral Health as a structured course of treatment authorized by a PacifiCare Behavioral Health clinician and for which a member has been admitted to a facility, received behavioral health services and discharged.

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**KAISER**	**PACIFICARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Chemical Dependency			
Inpatient	100% of covered expenses; limited to 30 days per calendar year per member	No charge when necessary for medical management of withdrawal symptoms	100% of covered charges; limited to 30 days per calendar year per member
Outpatient	100% of covered expenses; limited to 2 treatment episodes per calendar year per member	No charge	100% of covered charges; limited to 2 treatment episodes per calendar year per member
Prescription Drugs	80% of reasonable and customary charges	$2.50 per prescription	$3 per prescription

SCHEDULE OF DENTAL BENEFITS		
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE**	**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	No charge
- 13th month and after	100% of reasonable and customary charges	No charge
Orthodontic Enrolled in Plan		
- first 24 months	90% of reasonable and customary charges	$1,000
- 25th month and after	100% of reasonable and customary charges	$1,000

SCHEDULE OF VISON BENEFITS	
DESCRIPTION OF BENEFITS	**COVERAGE**
Calendar Year Maximums	
Employee Only Employee and one dependent Employee and two or more dependents	$300 $450 $600
	TRUST PAYS
Exam	100% of allowable charges
Lenses and Contacts	100% of allowable charges
Prescription Sunglasses	100% of allowable charges
Frames	$120 maximum per frame

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 per calendar year