Transportation Communications Union-IMA

&

Los Angeles County Metropolitan Transportation Authority

Health and Welfare Trust Fund

Summary Plan Description

For Active and Retired
Employees and their Dependants

April 2024

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

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

We are pleased to present you with this new Summary Plan Description ("SPD"), which describes the Plan of Benefits (the "Plan") provided by the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund (the "Trust"). This SPD covers changes to the Plan as of January 1, 2024. It replaces all previous SPDs.

The SPD describes for you the important features of the Plan, including:

- How to become eligible for Plan benefits and the rights of eligible participants;
- What benefits are provided;
- How to elect among the different benefits available;
- What is excluded from coverage; and
- How to file a claim for benefits and appeal a denied claim.

You should share this SPD with your family, since they also may be eligible to receive Plan benefits available through the Trust. Since several changes have been made since the printing of the last SPD, you should be sure to familiarize yourself with current Plan benefits available and determine whether you are eligible for them. Please note however, that in the event of a conflict between this SPD and the Trust's Plan(s) of benefits, the Plan(s) of benefits or the Trust Agreement, if applicable, will always control.

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

Sincerely,
BOARD OF TRUSTEES

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I.
IMPORTANT INFORMATION

A. Authorized Sources of Information

If you have any questions about your benefits, you may only rely upon: (1) this SPD, the Rules and Regulations of the Trustees,, the Plan(s) of benefits, the Trust Agreement, and any supplements and amendments thereto; the written statements of the Board of Trustees or the Administrative Office; and (3) with respect to fully insured or prepaid (HMO) benefits, the Evidence of Coverage and the terms of any insurance policy or contracts between the Trust and the insurer or HMO. You may not rely on any oral statements. Furthermore, written representations made by individuals other than the Board of Trustees or the Administrative Office are not authoritative sources of information. Questions as to eligibility, benefits, and other matters regarding the Plan should be submitted in writing to the Administrative Office at: Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, California 90017-1906.

B. Availability of Trust Resources

The benefits provided by the Trust, either directly or through the purchase of insurance contracts, can be paid only to the extent that the Trust has available adequate resources for such payments. The Los Angeles County Metropolitan Transportation Authority (the "MTA") is not obligated to provide these benefits, it is only obligated to make contributions as required in its collective bargaining agreement with Transportation Communications International Union Local 1315 (the "Union").

The health dental and vision benefits provided through United Health Care, Kaiser Permanente, United Concordia and VSP are insured benefits, meaning the Trust makes premium payments on behalf of electing Employees and Retirees eligible for those benefits and the insurance companies, not the Trust, is exclusively responsible to pay the benefits provided under the insurance policies. The benefits provided by the Trust under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefit **are not** insured by any contract of insurance, and there is no liability on the Trust, the Board of Trustees, or any other individual or entity to provide payment over and beyond the amount in the Trust collected and available for such purpose.

C. Amendment and Termination

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

- To terminate or amend the amount of or eligibility rules for any benefit provided under the Plan whether self-funded or through an insurance contract, even though that termination or amendment affects claims which have already accrued;
- To terminate the Plan including any insurance contract, even though termination affects claims which have already accrued;
- To alter or postpone the method of payment of any benefit whether self-funded or insured; and/or
- To amend or rescind any other provisions of the Trust or the Trust's Plan(s) of benefits.

D. Mistake

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

- You or such person is not eligible or entitled to the benefits; or
- The Trust pays such benefits by mistake for any reason.

If you do not reimburse the Trust, the Board of Trustees, in its sole discretion, may deduct or offset any such monies from your future benefits. If the Trust files any legal action against you to recover monies, you are required to pay all attorney fees and costs of the Trust, no matter whether the legal action proceeds to judgment.

E. Discretion

The Board of Trustees at all times has unrestricted power and discretion to: (1) interpret the Trust Agreement, this SPD, any other document governing the Plan, and any amendments thereto; and (2) determine any facts relating to any application for benefits or the operation of Trust or the Plan. The Board of Trustee's interpretation is final and conclusive on all parties dealing with the Trust.

F. Grandfathered Health Plan Status

The Board of Trustees believes that the self-funded fee for services health care benefits provided by this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, California 90017-1906, (800) 222-2222. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

G. Opt-Outs of Federal Law Benefit Mandates

The Plans of Benefits maintained by the Trust are governmental plans, which are subject to special rules and conditions that permit the Trustees wider discretion as to the design of medical care benefits offered by the Trust. The Trustees reserve the right to opt-out of any generally applicable federal law benefit requirements to the extent permitted by federal law.

II.
ELIGIBILITY RULES

A. Eligibility for Coverage

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

You are eligible for benefits under the Trust, whether provided directly or through insurance

contracts, as a "Full Time Employee" beginning on the first day of the month coinciding with or next following the date on which you have completed 60 days of continuous employment, but only if you also satisfy **all** of the following requirements:

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

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

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

Your eligibility may continue while you are on an approved leave of absence or on an authorized sick leave as explained at Section D of this Article II.

Full Time Employee benefits can include coverage for Dependents.

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

You are eligible for benefits under the Trust, whether provided directly or through insurance contracts, as a "Part Time Employee" beginning on the first day of the month coinciding with or next following the date on which you have completed 60 days of continuous employment, but only if you satisfy **all** of the following requirements:

- You are an active part-time employee of the MTA, as determined in under the collective bargaining agreement between the Union and the MTA.
- You are covered by the terms of the collective bargaining agreement between the Union and the MTA.
- You pay a monthly participant contribution, in an amount determined by the Trustees, for each month of eligibility. (Participant contributions to the Trust will be deducted automatically by the MTA through payroll deduction.)

Part Time Employee benefits do not include coverage for Dependents.

3. Retired Employees ("Retirees")

A. Hired On or Before September 7, 1991

If you were hired by the MTA in a TCU-covered position on or before September 7, 1991, you are eligible for benefits under the Trust as a "Retiree", but only if you satisfy **all** of the following requirements:

- You retired from active employment with the MTA and/or its predecessors and you do not work in active employment for the MTA.
- You are younger than 65 years of age.
- You completed at least 23 years of service with the MTA and/or its predecessors as a

Full Time Employee prior to your retirement.

- MTA is required, under Article 37 of its collective bargaining agreement with the Union, to make contributions to the Trust on your behalf.

- You pay in advance a participant contribution on a quarterly basis, in an amount determined by the Trustees, for each 3-month period of eligibility. (The Trust will bill you for your participant contribution each quarter.)

B. Hired After September 7, 1991

If you were hired by the MTA in a TCU covered position after September 7, 1991, you are eligible for benefits under the Trust as a "Retiree", but only if you satisfy **all** of the following requirements:

- You have reached the age of 55 years at the time you retire from active employment with the MTA and/or its predecessors generally in TCU-covered employment.

  - If you are a TCU member who enters the pension drop program before the age of 55 and transfers to a non-TCU covered position with MTA, you will satisfy this requirement if you retire from active employment with MTA after reaching the age of 55.

- You are younger than 65 years of age.

- You completed at least 23 years of service with the MTA and/or its predecessors as a Full Time Employee prior to your retirement.

- MTA is required, under Article 37 of its collective bargaining agreement with the Union, to make contributions to the Trust on your behalf.

You pay in advance a participant contribution on a quarterly basis, in an amount determined by the Trustees, for each 3-month period of eligibility. (The Trust will bill you for your participant contribution each quarter.)

C. Fewer Than 23 Years of Service with MTA

If you retire on or after June 1, 1974, with fewer than 23 years of service with the MTA, you are eligible for benefits under the Trust as a "Retiree", but only if you satisfy **all** of the following requirements:

- You reached age 62 at the time you retire from active employment with the MTA and/or its predecessors.

- You are less than 65 years of age.

- You completed at least 10 years of service with the MTA and/or its predecessors as a Full Time Employee at the time you retire.

- MTA is required, under Article 37 of its collective bargaining agreement with the Union, to make contributions to the Trust on your behalf.

- You pay a participant contribution on a quarterly basis, in an amount determined by the Trustees, for each 3-month period of eligibility. (The Trust will bill you for your participant contribution each quarter.)

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

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

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

The Plan defines "Dependent" as:

- Your lawfully married spouse or registered Domestic Partner.
- Your child who is 25 years of age or younger, including your legally adopted child or foster child or those of your spouse or Domestic Partner.
- Your stepchild (i.e., the child of your lawfully married spouse or Domestic Partner).
- A child for whom you, your spouse, or your Domestic Partner have been designated the court appointed legal guardian or conservator. Proof of legal guardianship or conservatorship must be submitted to the Administrative Office upon request.
- Your unmarried child who is 26 years of age or older, if the child is disabled and incapable of self-sustaining support by reason of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching age 26. Written evidence of disability must be submitted within 31 days of attainment of the age limit and must be periodically reconfirmed to the Administrative Office upon request. This disability extension will continue until the earlier of: (1) the date the child ceases to be eligible for reasons other than age; (2) the date the child ceases to be disabled; or (3) the 31st day after the Trust requests additional proof of the child's disability and you fail to furnish such proof.

5. Payment of Participant Contributions via the Flexible Benefits Plan

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

6. Special Rule Pertaining to Dependent Spouse Coverage

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

7. Effective Date of Dependent Coverage

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

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

- A new Dependent becomes eligible on the first of the month following the date he or she has satisfied the Dependent coverage requirements.

Newborns, however, are eligible as of the date of birth. **All new Dependents must be enrolled within 30 days of becoming a Dependent.**

8. National Medical Support Notices

Special rules apply to Dependent children of an Employee or Retiree added to the health coverage or required covered pursuant to a National Medical Support Notice (NMSN). An NMSO is a court order requiring the Plan to provide health coverage for a child of an Employee or Retiree who is typically involved in a divorce. Please contact the Administrative Office if you need further information regarding NMSOs or the Plan's procedures regarding NMSN and NMSO determinations.

9. Special Enrollment Rights under HIPAA

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

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

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

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

10. Termination of Coverage

(a) Employees

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

- The last day of the month in which your employment with the MTA ends.
- The effective date of the Plan's termination if the Plan is terminated by the Board of Trustees.
- The first day of any month for which the Fund does not receive a timely ~~any~~ contribution in the amount required for coverage from you or the MTA.

11. Retirees

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

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

12. Dependents

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

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

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

If any quarterly contribution required for coverage for an Employee or Retiree and/or his/her dependents is not paid by the due date established by the Trust, full coverage under the Trust for you and all coverage under the Trust for your Dependent(s), if applicable, will end on the later of the payment due date or the expiration date of the coverage for which required contributions were timely paid Only Trust medical benefits will continue to be provided to the Employee or Retiree who has not timely or completely paid required contributions. (Employees and Retirees who have not paid required contributions do not receive Dental, Vision, Wellness, Supplemental Accident, Life Insurance, or Accidental Death and

Dismemberment benefits from the Trust while coverage is limited to medical benefits only). Payment is considered made on the date postmarked or hand-delivered to the Administrative Office. If you miss or are late paying your required contributions, you cannot reinstate the coverage lost (by you and/or your Dependents, if applicable, until the next open enrollment period. Stated another way, if you make late or short required contribution payments, you will have reduced coverage and your dependents will have no coverage for the remainder of the year. You and your Dependents will be permitted to re-enroll for benefits at the Trust's next annual open enrollment period, provided you first pay a $150 reinstatement fee as well as any unpaid participant/dependent contributions. In addition, the Trust may offset (i.e., reduce) any benefits payable to you or your Dependents by an amount equal to the unpaid quarterly contribution.

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

14. Continuation of Coverage during Military Service (USERRA)

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

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

If you are an Employee, and you are absent from covered employment due to military service, you may elect to continue Trust coverage for yourself and/or your enrolled Dependents for up to 24 months. This USERRA coverage begins when your Trust coverage otherwise ends. For example, if the MTA continues your Trust coverage during part of your military leave, your USERRA coverage would begin after your MTA-provided coverage ends. You must pay a monthly premium for this USERRA coverage if your military service absence is longer than 30 days. The monthly premium will be the same as the premium for COBRA coverage (Article II, Section A (25), on page 14). If you are absent for 30 days or less, you will be required to pay only your normal participant contribution for you and your Dependents, if applicable.

Your right to USERRA coverage may terminate early if: (1) you are discharged from military service, and you do not return or reapply for employment with the MTA within the required timeframe after your military service ends; or (2) you do not have reemployment rights due to a less than honorable discharge from the military.

15. Selection of USERRA Coverage

MTA's Military Leave Policy requires that you notify the MTA of your military leave of absence. The MTA will then notify the Administrative Office of your military leave and when your Trust coverage will end. The Administrative Office will mail you a USERRA election form. If you want USERRA coverage, you must elect it for yourself and any of your covered Dependents unless military necessity prevents or otherwise makes your compliance impossible or unreasonable. You do this by completing and returning the USERRA election form by the same deadline applicable to electing COBRA coverage (refer to Article II. Section A (24)). You must also pay for USERRA coverage. The amount of the payment and the payment rules for USERRA coverage are the same as the payment amount and rules that apply to COBRA coverage. Unlike with COBRA, however, your Dependents do not have an independent right to select USERRA coverage if you reject it.

You may choose to be covered under both COBRA and USERRA if you are eligible for both and there is no additional charge for doing so. The maximum coverage under USERRA may be up to 6 months longer than under COBRA.

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

16. Employment After Military Service - Reinstatement of Benefits

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

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

17. During a Leave of Absence

A Full Time Employee going on a personal leave of absence may continue Employee and Dependent coverage by submitting, in advance, the required monthly participant/dependent contributions to the Administrative Office for the duration of the leave. The amount to be paid is the amount the MTA would normally pay for the Employee plus, if applicable, the regular participant/dependent contribution. (Payments are due and payable in the same manner as COBRA payments, see Article II, Section A (25), on page 14).

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

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

The MTA may, at its discretion, pay the employer contribution for those Employees who are on a confirmed military leave of absence (Please see Article II section A (15), page 8).

18. COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) gives you and your covered Dependents the right to temporarily extend your Trust-sponsored group health plan coverage (called "COBRA coverage") at group rates following certain life events (called "qualifying events") that would normally end your coverage. **Please understand that you and/or your Dependent(s) must pay monthly COBRA premiums directly to the Administrative Office to obtain COBRA coverage.** Below is a summary of how COBRA coverage works and your rights and obligations regarding COBRA coverage if you or your beneficiary elect it. For more information about COBRA, contact the Administrative Office.

19. What Benefits Can Be Continued Under COBRA?

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

You must select one of two options if you elect COBRA coverage: (1) you can choose to continue your medical benefits only; or (2) you can continue your medical, dental, vision, wellness, and hearing aid benefits. In any case, you must remain in the plan in which you were enrolled at the time of the qualifying event (i.e., indemnity or HMO). You can change plans at open enrollment, but you cannot change the option that you elected.

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

20. What are COBRA Qualifying Events?

For an Employee

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

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

Even if you do not elect COBRA coverage for yourself, each of your covered Dependents will have a separate right to elect it.

SO, IT IS IMPORTANT THAT YOU AND ALL OF YOUR DEPENDENTS UNDERSTAND THEIR COBRA RIGHTSUNDER THIS SECTION OF THE BOOKLET.

For a Dependent Spouse

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

- The Employee’s hours of employment are reduced;
- The Employee’s employment ends for any reason other than his or her gross misconduct;
- Divorce from the Employee or Retiree; or
- The death of the Employee or Retiree.

For a Dependent Child

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

- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The child ceases being eligible for coverage as a "Dependent" as defined under this Plan; or
- The death of the Employee or Retiree.

A legal guardian or parent of a dependent child who is eligible to elect COBRA coverage can elect coverage for his/her child or ward.

21. When Does COBRA Coverage Begin?

Your COBRA coverage start date depends on the qualifying event:

- If the qualifying event is termination or reduction in hours of employment: Trust coverage will end on the last day of the month in which the qualifying event occurs, and COBRA coverage will begin on the first day of the following month.
- If the qualifying event is death: Trust coverage will end on the last day of the month for which the MTA makes its last contribution with respect to decedent, and COBRA coverage will begin on the first day of the following month.
- If the qualifying event is divorce or the cessation of "Dependent" child status or, for adult children who no longer are eligible for coverage upon reaching age 26: Trust coverage will end on the last day of the month in which the divorce occurred or the child no longer meets the requirements for Dependent coverage, and COBRA coverage will begin on the first day of the following month.

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

22. How Long Does COBRA Coverage Last?

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

- If the qualifying event is termination or reduction in hours of employment, the maximum COBRA coverage period is 18 months.
- For all other qualifying events, the maximum COBRA coverage period is 36 months.

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

- **Disability Extension**

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

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

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

- **Second Qualifying Event**

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

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

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

Termination of Employment or Reduction in Hours After Medicare Entitlement - Special Rule.

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

Special Extension of COBRA coverage under California law – HMO only

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

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

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

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

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

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

23. Your Responsibility to Notify the Administrative Office

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

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

Transportation Communications International Union
Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906
(800) 427-5342

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

Your employer is responsible for notifying the Administrative Office of your death, termination of employment or reduction in hours. However, **you or your family member should also notify the Administrative Office promptly and in writing** if any such event occurs to assure prompt handling of your COBRA rights.

24. Electing COBRA Coverage

After the Administrative Office has determined that a qualifying event has occurred, it will send you and/or your Dependents a COBRA election form and other information regarding COBRA coverage. Notice to Dependents children generally will be mailed to one or both of the parents of the child. You will have at least 60 days from the later of the date your coverage ends or the date the Administrative Office sends you the COBRA election form to make your election.

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

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

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

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

25. Paying for COBRA Coverage

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

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

- All payments must be made by check, cashier's check, or money order.

- The first COBRA coverage payment must be made within 45 days after the date of your COBRA election (i.e., the date your COBRA election form is postmarked or hand-delivered to the Administrative Office). It is best that the payment be received by the Administrative Office no later than the 20th day of the month prior to the month for which you desire coverage to avoid possible delays in claim payments and eligibility problems. The first payment must cover all of months from the date you lost regular Trust coverage, including the month in which the first payment is made.

- Subsequent COBRA coverage payments must be made monthly to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. For example, if you want COBRA coverage for the month of February, payment should be received by January 20th. Failure to make a monthly payment within 30 days of the

beginning of the coverage month will result in termination of COBRA coverage as of the end of the period for which the last timely payment was made.

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

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

26. Termination of COBRA Coverage

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

- The date the 18, 29, or 36 months maximum COBRA coverage period has been exhausted;
- The date that the Trust no longer provides group health coverage to any Participants;
- The date you fail to make a COBRA premium payment in full and on time;
- The date a Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA, unless entitlement to Medicare is for a reason other than age;
- The date a Qualified Beneficiary, after electing COBRA coverage, becomes covered under another group health plan;
- During a disability extension period, the last day of the month after the month in which the SSA makes a final determination that the Qualified Beneficiary is no longer disabled;
- The date the Trust determines that the Qualified Beneficiary's COBRA coverage must be terminated for cause (on the same basis as would apply to similarly situated non-COBRA Trust Participants); or
- The date the MTA ceases to contribute to the Trust, if the MTA provides alternate group health coverage to a class of employees formerly covered under the Trust (in which case, benefits may be continued through the MTA's new plan).

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

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

27. Conversion Option

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

28. If You Have Any Questions About COBRA

If you have questions about your COBRA coverage, contact the Administrative Office or the State of California at Keep Your Plan Informed of Address Changes

It is up to you to protect you and your family's coverage rights. You should keep the Administrative Office informed of any changes in the addresses of family members, as well as changes in marital status and the addition of new Dependents. You should also keep copies of any notices you send to the Administrative Office.

29. California Insurance Marketplace (California Exchange)

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

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

III.
CHOICE OF PLANS

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

If, after January 1, 2006, you choose not to enroll in one of the Trust's plans, your employer will pay you $100 a month, provided that you decline in writing your coverage under all the benefits provided by the Trust. You can only make this choice if you are covered as a dependent under your spouse's/Domestic Partner's other medical, dental and vision insurance.

A. Types of Benefits

1. Medical Benefits

Three options are available for medical benefits:

Fee for Services Plan. The Fee-For-Service Medical Plan provides benefits that are paid directly by the Trust. After payment of the applicable deductible and any copayment that applies, the Trust will pay a portion of covered medical charges. You are always responsible for payment of the portion of

the covered charges that the Trust does not pay. If you choose this option, you and your enrolled Dependents will be covered under the Trust's Fee-For-Service Medical Plan for Hospital and medical services and supplies. You may use any Physician or Hospital in the United States. However, if you use a Preferred Provider Organization (PPO) Hospital or Physician, your out-of-pocket costs, including co-pays and co-insurance will be lower. And, PPO providers may provide you with converted services at lower costs to both you and the Trust.

This option includes the Mandatory Sav-Rx Prescription Drug Program. You must obtain your outpatient prescription drugs at Sav-Rx network pharmacies and use the Sav-Rx Card. Only prescription drugs obtained at and covered by the Trust's Sav-Rx program are covered benefits. **If you do not use the Sav-Rx Card at a Sav-Rx network pharmacy to obtain your prescription drugs, your prescription drug claim will be denied. [See Article VI, page 31 for more on your Rx coverage].**

Kaiser Permanente Pre-paid Medical Plan. A prepaid medical plan provided by Kaiser Permanente. Services that are prescribed or directed by a Kaiser Permanente Physician are provided either at no charge to you or at specified Co-payments. **Kaiser Permanente will provide you with a booklet describing its services and benefits and the procedures for filing claims for covered services and supplies. You also can access it on-line at www.Kaiser.com .**

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

This Plan does not include the Mandatory Sav-Rx Prescription Drug Program. You must obtain your outpatient prescription drugs at a Kaiser Permanente network pharmacies. Only prescription drugs obtained at and covered by the Kaiser Permanente program are covered benefits. **If you do not use a Kaiser Permanente network pharmacy for obtaining your outpatient prescription drugs, your prescription drug claim will be denied.**

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

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

This Plan does not include the Mandatory Sav-Rx Prescription Drug Program. You must obtain your outpatient prescription drugs at participating UnitedHealthcare network providers. Only out-patient prescriptions covered under the UnitedHealthcare program and obtained from UnitedHealthcare network providers are covered benefits. **If you do not use UnitedHealthcare network pharmacy for obtaining your prescription drugs, your prescription drug claim will be denied.**

2. Dental Benefits

There are two dental plan options from which you can choose:

Fee for Services Plan. The Fee-For-Service Dental Plan provides benefits that are

paid directly by the Trust. After payment of the applicable deductible or copayment, if any, the Trust will pay a portion of the covered dental charges, and you will be responsible for payment of the balance. If you choose this option, you and your enrolled Dependents will be covered under the Trust's Fee-For-Service Dental Plan and you will have the option to use both the First Dental Health Preferred Provider (PPO) & Exclusive Provider (EPO) dental networks for dental services. Using a First Dental Health PPO or EPO dental network-Dentist will reduce dental costs for you and also for the Trust. **(Please see Article VII, pages 32 to 34.)**

United Concordia Prepaid Plan. 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.

Dental Benefits Opt-Out Choice. Dental coverage under the Trust is optional. You may decline dental coverage upon initial enrollment or drop your existing dental coverage during an annual open enrollment period. Since dental benefits are provided by the Trust at no additional cost to you, opting-out will not reduce your contribution amounts; you will pay the same amount for Trust coverage with or without dental benefits. Furthermore, by opting-out, your enrolled Dependents (if any) will also lose dental coverage under the Trust, and the Trust will not be liable for the cost of any dental service received by you or your Dependents.

3. Vision Benefits.

Two VSP vision plans are available.

VSP Choice Plan. The VSP Choice Plan is a prepaid vision plan.

VSP Signature Plan. The VSP Signature Plan-provides a vision allowance of $350 per calendar year. If you are enrolled in a prepaid medical plan, the cost of an eye exam is not counted towards the allowance, if an eye exam is conducted through the prepaid medical plan.

VSP will provide you with a booklet describing each of these plans, along with the services and benefits provided.

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

VSP network providers must be used to obtain the full benefit. (See Article X, page 36.) For details, please see the booklets provided by VSP.

Vision Benefits Opt-Out Choice. Vision coverage under the Trust is optional. You may decline vision coverage upon initial enrollment or drop your existing vision coverage during an annual open enrollment period. Since vision benefits are provided by the Trust at no additional cost to you, opting-out will not reduce your contribution amounts; you will pay the same amount for Trust coverage with or without vision benefits. Furthermore, by opting-out, your enrolled Dependents (if any) will also lose vision coverage under the Trust, and the Trust will not be liable for the cost of any vision service received by you or your Dependents.

4. Hearing Aid Benefits.

The Fee-For-Service Hearing Aid Plan provided directly through the Trust is available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article VIII, page 34).

Hearing Aid Plans Opt-Out Choice. Hearing aid coverage under the Trust is optional. You may decline hearing aid coverage upon initial enrollment or drop your existing hearing aid coverage during an annual open enrollment period. Since hearing aid benefits are provided by the Trust at no additional cost to you, opting-out will not reduce your contribution amounts; you will pay the same amount for Trust coverage with or without hearing aid benefits. Furthermore, by opting-out, your enrolled Dependents (if any) will also lose hearing aid coverage under the Trust if applicable, and the Trust will not be liable for the cost of any hearing aids or haring aid service received by you or your Dependents.

5. Wellness Benefits.

The Extra Mile Benefits Wellness Program is provided directly by the Trust and is available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article IX, page 35.)

6. Life Insurance Benefits.

Life insurance benefits are provided by the Prudential Insurance Company of America and are available to eligible Employees and Retirees. (Please see Article XI, page 37.)

7. Accidental Death & Dismemberment Benefits.

Accidental death & dismemberment benefits are provided by Prudential and are available to eligible Employees and Retirees. (Please see Article XI, page 38.)

8. Supplemental Accident Benefits.

Supplemental accident benefits are provided directly by the Trust and are available to eligible Employees, Retirees, and their enrolled Dependents. (Please see Article XIII, page 38.)

9. EAP Benefits.

An Employee Assistance Program is provided by Optum EAP and Anthem EAP and is available to Employees, Retirees, Dependents and those in the same household of the person enrolled in the Funds health plans. Please see Article XIV, page 38.

EAP Benefits Opt-Out Choice. The EAP provides additional medical care and other benefits to those provided under the Funds Medical Plans. EAP coverage under the Trust is optional. You may decline EAP coverage upon initial enrollment or drop your existing EAP coverage during an annual open enrollment period. Since EAP benefits are provided by the Trust at no additional cost to you, opting-out will not reduce your contribution amounts; you will pay the same amount for Trust coverage with or without EAP coverage benefits. Furthermore, by opting-out, your enrolled Dependents (if any) and those in your household will also lose EAP coverage under the Trust, and the Trust will not be liable to provide any medical care EAP benefits that are not separately available under the Funds Medical Plans.

10. Payment in lieu of Coverage.

When the Employee or Retiree withdraws, are there any benefits through the Trust?

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

- Your other insurance coverage ceases, and you enroll in Trust coverage;
- You are no longer eligible for coverage under the Trust (for example, because your employment is terminated or you attain age 65); or
- You enroll in Trust Coverage during an annual open enrollment period or in connection with a "Change in Status Event" or "Special Enrollment Event."

MTA, not the Trust, determines whether you meet the requirements to receive $100 per month because you have declined Trust coverage. The $100 per month is not a Trust Fund benefit.

11. How to Make Your Health Plan Selection

You must complete an enrollment ~~card~~ form to choose your medical, dental, and vision plan and designate the beneficiary for your life and AD&D Insurance. Enrollment forms are available at the Administrative Office by calling (800) 427-5342. You may also receive an enrollment form from your union representative during orientation. ***A completed enrollment card form is essential before action can be taken on claims.***

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

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

Where you should go to find out the details of what health, dental and vision benefits are available to you depends on the medical, dental and vision plans that you elect.

If you elected coverage under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the details about those benefits are described at the end of this Summary. The details of your Fee-For-Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefits also are described in this summary. The details of your Vision (VSP), Life Insurance (Prudential) and AD&D benefits (MHN) are described in separate summaries of benefits and certificates of insurance or evidence of coverage that were provided to you and available on-line as described later in this booklet.

If you elected pre-paid, insured medical and pre-paid, insured dental benefits, provided by Kaiser Permanente, UnitedHealthcare, United Concordia, VSP, Prudential, Anthem and/or Optum, your benefit rights will only be determined, as applicable, by: (1) the Kaiser Permanente Group Service

Agreement; (2) the UnitedHealthcare Group Master Contract; (3) the United Concordia Group Dental Service Agreement; (4) the VSP Service Agreement; (5) the Prudential Life Insurance Service Agreement; (6) the Anthem and/or (7) the Optum Service Agreement, as well as the written benefit descriptions (including the Evidence of Coverage or the contract, ~~or~~ policy or certificate of insurance) from each of these respective insurers.

13. When To Make Your Health Plan Selection

You must select a medical, dental, and vision plan when you first become eligible for Trust benefits. All eligible Dependents must be enrolled in the same plans in which you enroll. Once you have made your selection, you may not change plans until the Trust's next annual open enrollment period, which is held in November of each year, or if you or a Dependent have a special enrollment right. However, you can change your medical plan election early (from a pre-paid plan to the Trust's self- funded fee for services plan), if you are enrolled in a prepaid plan and move out of the service area before the next annual open enrollment period. If you lose eligibility before an annual open enrollment period, but reestablish eligibility at a later date, you also will be able to change your plan selection at that time.

14. Summary Outline of Benefit Plan Features

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

- The Fee-For-Service Medical Plan provided directly by the Trust;
- The Mandatory Sav-Rx Prescription Drug Program;
- The Fee-For-Service Dental Plan provided directly by the Trust or the prepaid dental plan provided by United Concordia;
- The Fee-For-Service Hearing Aid Plan provided directly by the Trust;
- The vision plans provided by VSP (Part Time Employees, however, are only eligible for the VSP Signature Plan);
- The Extra Mile Benefits Wellness Program provided directly by the Trust;
- The Supplemental Accident Benefit Plan;
- The life insurance benefit and AD&D benefits (for Employees and Retirees only) provided by Prudential; and
- The EAP program provided by Optum and Anthem.

Election of Pre-paid Medical Plan The following benefits are available to Employees and Retirees enrolled in the prepaid medical plan provided by Kaiser or UnitedHealthcare, including prescription drug benefits provided by such programs:

- The prepaid medical plan provided by Kaiser or UnitedHealthcare;
- The Fee-For-Service Dental Plan provided directly by the Trust or the prepaid dental plan provided by United Concordia;
- Mental health and Substance Use benefits provided under the prepaid medical plan selected by the Employee or Retiree;

- The Fee-For-Service Hearing Aid Plan provided directly by the Trust;

- Vision plans provided by VSP (Part Time Employees, however, are only eligible for the VSP Signature Plan);

- The Extra Mile Benefits Wellness Program provided directly by the Trust;
- The Supplemental Accident Benefit; and

- The life insurance benefit and AD&D benefits (for Employees and Retirees only) provided by Prudential.

IV.
HOW TO FILE A CLAIM

A. For the Fee-For-Service Medical Plan (including the Sav-Rx Prescription Drug Program), the Fee-For-Service Dental Plan, the Fee-For-Service Hearing Aid Plan, the Supplemental Accident Benefit, and the Extra Mile Benefits Wellness Program

- Obtain a claim form from the Administrative Office;

- File one form for each claim;

- Complete Part I of the form, otherwise payment of your claim may be delayed;

- Have your Physician, Dentist, or other provider complete Part II of the form, attach itemized bills, and submit to the Administrative Office at:

  Transportation Communications International Union – Los Angeles County
  Metropolitan Transportation Authority Health and Welfare Trust
  1200 Wilshire Blvd., Fifth Floor
  Los Angeles, California 90017-1906

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

- ***A Claim also includes a request that participant cost-sharing for out-of-network emergency services and facilities, and out-of-network air ambulance services be no more expensive than for those services if they were in-network, and also that emergency procedures not be subjected to preauthorization, all in compliance with the No Surprises Act, codified at Title II of Division BB of the Consolidate Appropriations Act;***

- **BENEFITS WILL BE PAID BY THE TRUST ONLY IF A CLAIM IS FILED WITHIN ONE YEAR FROM THE DATE ON WHICH COVERED EXPENSES WERE INCURRED;**

- The Trustees may, at their discretion, extend this one-year time limit if you can show to the Trustees' satisfaction that it was not reasonably possible to file a claim in the one-year period. **See also, Article XV Exclusions and Limitations, section F, #16 at page 41;**

- A claim is considered filed when it is received by the Administrative Office or such

other location as may be indicated on the claim form, provided that it is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim; and

- If you want the Trust to make a direct payment to the Physician or the Hospital, you must authorize assignment of your benefits by completing the appropriate portion of the claims form. If you assign your claim to a PPO provider you do this, your claim will be filed directly by the physician or hospital. In either case payment will be made upon receipt of itemized bills and properly completed claim forms.

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

- For information on filing claims, please refer to the booklets provided by these organizations. Your claims are filed directly with the insurance carrier because the coverage that you elected is pre-paid by the Trust. You have no direct claim against the Trust for benefits provided by pre-paid coverages.

C. For Life Insurance or Accidental Death and Dismemberment Benefits:

- Contact the Administrative Office for a Prudential claim form and information on how to file a claim, including the proof required for payment of a claim. Your claim is filed directly with Prudential. Do not file a claim with the Trust. You have no direct claim against the Trust for Life insurance and/or accidental death and dismemberment coverage.

D. For the EAP program provided by MNH:

- **You must contact Optum for a referral by calling1-866-248-4096 or Anthem for a referral by calling 1-800-999-7222. Benefits will only be provided upon pre-authorization by Optum and/or Anthem.**

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

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

A. The Preferred Provider Organization (PPO).

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

No PPO-specific enrollment (or selection of a primary care doctor) 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. In addition, -non-PPO providers (Hospitals, Physicians, and other healthcare providers) often charge more than the**

Trust's Allowed Amount. When you use a non-PPO provider, you can be Balance Billed for charges above the Trust's Allowed Amount.

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. Deductibles and Co-Insurance Out-Of-Pocket Maximum for the Fee-For-Service Medical Plan.

After the calendar year deductible is satisfied, the plan will pay the stated percentages for Covered Expenses until the Participant's share of Covered Expenses total $1,000 during the calendar year, excluding the non-PPO Hospital admission deductible (called the con-insurance Out-of-Pocket Maximum). When this $1,000 co-insurance Out-of-Pocket limit Maximum is reached, the Trust will pay 100% of Covered Expenses incurred during the same calendar year by that same Participant or beneficiary. However, the Out-of-Pocket Maximum provision does not apply to certain expenses. The Deductible and co-insurance Out-of-Pocket Maximum are explained in more detail below.

C. 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. Each calendar year, the deductible applies separately to you and each enrolled Dependent, up to a maximum of $150 per family per calendar year. **Deductibles and co-pays don't count towards meeting your Out-of-Pocket Maximum.**

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

D. 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. **This deductible does not apply against the co-insurance Out-of-Pocket Maximum.**

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

E. "Out-of-Pocket Maximum".

The co-insurance "Out-of-Pocket Maximum" ("OOP Maximum") is $1,000 per person per calendar year, excluding the annual per person Deductible and 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 as their share of the cost for certain listed Covered Expenses during a calendar year is $1,000. Separate $1,000 OOP Maximums apply to the Participant and each covered Dependent.

Expenses that do not accumulate to the OOP Maximum: There are some out-of-pocket expenses you must always pay that do not count toward the OOP Maximum and are not paid at 100% when the OOP Maximum is met. These expenses include the following:

- Deductibles, including annual Deductible and the $250 non-PPO Hospital Admission Deductible;
- Participant and dependent contributions for coverage;
- Expenses for health care not covered by the Plan (including expenses over the 80% of the Allowed Amount for Out-of-Network Services and amounts over 80% of the Contract Rate for PPO provider for Physician services;
- Charges in excess of the Allowed Amount (i.e., Balance Billed charges), or a benefit maximum; and
- Expenses for benefits not provided through the Fee-for-Service Medical Plan (e.g., dental, orthodontic, vision, and hearing aid benefits).

F. Covered Expenses.

Covered Expenses are either (1) the Contract Rates for PPO providers or (2) the Allowed Amount for non-PPO providers, for the services and supplies listed below, which are certified by the attending Physician and determined by the Trust to be Medically Necessary for the care and treatment of Injury or Sickness and are not otherwise excluded from coverage.

Example: Assume that you have not paid your calendar year deductible of $50 per person, and your non-PPO surgeon charges $1,200 for a procedure, which the Trust determines has an Allowed Amount 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.

G. Inpatient Hospital Services.

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

If you or your Dependent is a registered bed patient in a Hospital for treatment of Injury or Sickness, the plan will pay 100% of the Contract Rate at a PPO Hospital or 80% of the Allowed Amount at a non-PPO Hospital for a semi-private room and other necessary services and supplies obtained during the confinement.

H. Outpatient Hospital Services.

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

I. Surgical Services.

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

J. Physician Visits.

If you or your Dependent receives non-surgical treatment from a Physician, the plan will pay 80%

of the Contract Rate if you use a PPO Physician and 80% of the Allowed Amount for a non-PPO Physician.

K. Physical Therapy, Acupuncture Treatment and Chiropractic Care.

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

L. Maternity Care.

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

M. Well Child Care.

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

N. Physical Exam.

The plan will pay 80% of the Covered Expenses for ~~a~~ one routine physical exam and pap smear (as applicable) per calendar year for Participant. A physical exam is limited to an intermediate office visit, CBC, urinalysis, and EKG (treadmill test is excluded). The amount payable when using PPO providers is 80% of the Contract Rate; when using non-PPO providers, the plan pays 80% of the Allowed Amount.

O. Skilled Nursing Facility.

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

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

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

P. Other Services and Supplies.

The plan will pay 80% of the Covered Expenses for the following:

(Note: The amount payable when using PPO providers is 80% of the Contract Rate; when using non-PPO providers, the payment is based on 80% of the Allowed Amount, and you may be Balance Billed

for charges above the Allowed Amount.)

- Services of a Physician for Emergency visits to a Hospital and home visits;
- Home visits by therapists, if Medically Necessary;
- Treatment by a Physician, Dentist, or dental surgeon for Injuries to natural teeth and for a fractured jaw, as well as related x-rays which are required because of an accident;
- Services of a Registered Nurse;
- Services of a qualified speech therapist to restore speech loss or correct an impairment due to: (1) a congenital defect for which corrective surgery has been performed; or (2) an Injury or Sickness which results in a hearing loss, except where caused by mental, psychoneurotic or personality disorder, or a congenital defect;
- Services of a licensed physiotherapist, including tests to diagnose, but excluding educational testing;
- Drugs and medicines requiring the prescription of a Physician and obtained at a Sav-Rx network pharmacy;
- Licensed ambulance service to the nearest Hospital where care and treatment of the Injury or Sickness can be given;
- Diagnostic x-ray and laboratory services;
- Required allergy testing;
- Artificial limbs, eyes, larynx, or surgical implants; home hemodialysis equipment; surgical dressings; casts, splints, trusses, braces, or crutches; rental of wheel chairs (not to exceed the purchase price), Hospital bed, or iron lung and oxygen and the rental of equipment for its administration;
- Blood transfusions;
- Radium, radiation therapy, inhalation therapy, and sensory integration therapy;
- Modification to orthopedic shoes, excluding the cost of the shoes;
- Family planning; and
- Voluntary sterilizations.

Q. Gene, Cellular, and CAR-T Therapies

- These treatments are covered when prescribed by a physician and the treatment must be approved by the Food and Drug Administration for the use it is being prescribed for, at the time the treatment is provided, and the Participant must comply with all applicable step-therapy and prior authorization protocols. The Participant must also comply with, and participate in, the Plan's case management

programs. Coverage is provided for all phases of related treatment, including but not limited to, genetic testing, treatment, procedures, services, supplies, and medicines provided in connection with admission, cell extraction, administration of the medication, as well as any necessary treatment and follow up care. Approved treatments will be subject to the Plan's cost sharing provisions (deductibles, copayments, coinsurance) as applicable. Cost sharing requirements will vary if the treatment is administered by out of network providers, subject to any applicable restrictions of the No Surprises Act.

R. Limitations and Exclusions.

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

- Services or supplies not prescribed, recommended, or approved by a Physician or non-experimental and medically necessary;

- Services or supplies that are not Medically Necessary for the treatment of a Sickness or Injury, unless specifically covered under the Medical Plan;

- Cosmetic surgery, unless due to an accident occurring while covered, or to correct birth or congenital deformities or restorative surgery performed during or following mutilative surgery required as a result of illness or injury. This exclusion does not apply to cosmetic surgery to breast(s) following a mastectomy or to Medically Necessary procedures in connection with gender reassignment surgery;

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

- Dental treatment other than as described under Covered Expenses;

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

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

- Custodial care and homemaker services;

- Education and vocational training;

- Expenses applied toward the satisfaction of a deductible;

- Acupuncture administered as surgery;

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

- Transportation charges, unless covered under ambulance services;

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

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

- Routine chiropractic care that is not Medically Necessary;

- Heart, heart/lung, or liver transplants;

- Radial keratotomy or other surgery to correct visual acuity;

- Services to reverse voluntary surgically induced infertility;

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

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

- Dependent child maternity and delivery charges;

- Ambulance services for transportation only to suit the patient's or Physician's convenience.
- Physical fitness programs or club memberships;

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

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

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

S. EXPENSES THAT DO NOT COUNT AGAINST YOUR OOP MAXIMUM.

Your share of the following claims will not count against your OOP Maximum:

- Deductibles, including annual Deductible and the $250 non-PPO Hospital Admission Deductible;

- Participant and dependent contributions for coverage;
- Expenses for health care not covered by the Plan (including expenses over the 80% of the Allowed Amount for Out-of-Network Services and amounts over 80% of the Contract Rate for PPO provider for Physician services;
- Charges in excess of the Allowed Amount (i.e., Balance Billed charges), or a benefit maximum; and
- Expenses for benefits not provided through the Fee-for-Service Medical Plan (e.g., dental, orthodontic, vision, and hearing aid benefits).

T. SPECIAL COVERAGE RULES

- **SPECIAL EMERCENCY RULES**

This Plan provides coverage for emergency services as provided in the above schedule of benefits. Emergency Services are not subject to preauthorization requirement and are covered regardless of whether the Provider or facility is in-network or out-of-network. The cost sharing to a Participant will be the same regardless of whether the emergency services provider or emergency facility provider or facility is in-network or out-of-network. Coverage of an out-of-network emergency services provider or facility will be no more restrictive than the coverage for an in-network emergency service provider or facility.

To the extent that the Fee for Services Plan covers or is required to cover air ambulance services, the cost to a Participant will be the same for out-of-network air ambulance services as in-network air ambulance services. This section does not apply to ground ambulances.

- **CONTINUITY OF CARE**

If a medical provider or facility leaves the Plan's network and becomes an out-of-network medical provider or facility while a Participant is a Continuing Care Patient, the Participant may elect to continue to have the same benefits provided with the Medical Provider or facility for the earlier of: (1) 90 days following when the Medical Provider or facility leaves the network; or (2) when the Participant is no longer a Continuing Care Patient. The Participant is a continuing Care Patient if (i) Undergoing treatment for a serious and complex condition, which is defined as:

(i) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;

(ii) In the case of a chronic illness or condition, a condition that is:

a. Life-threatening, degenerative, potentially disabling, or congenital; and
b. Requires specialized medical care over a prolonged period of time.

(iii) Undergoing institutional or inpatient care; (iv) Scheduled to undergo non-elective surgery (including receipt of postoperative care with respect to a surgery); (v) Pregnant and receiving treatment from the Medical Provider or facility; or (vi) Terminally ill and receiving treatment for the illness from the Medical Provider or facility.

U. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

This coverage is subject to the plan's annual deductibles and applicable cost-sharing provisions (Coinsurance/Copayments).

V. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Trust has elected to comply with the optional federal law requirement that group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or insurer may pay for a shorter stay if the attending Physician (e.g., your Physician, Nurse, or a Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Administrative Office.

VI.
THE MANDATORY FEE FOR SERVICES PLAN
SAV-RX PRESCRIPTION DRUG PROGRAM

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

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

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

claim under the Fee-For-Service Medical Plan.

So long as a Physician has written a prescription for the drug and the prescription is filled at a Sav-Rx network pharmacy, the Plan will pay 80% of the Contract Rate for the drug. Contact the Administrative Office to get a copy of the Sav-Rx Prescription Drug Program and its list of the participating pharmacies in the Sav-Rx network.

VII.

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

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

Once the calendar year deductible is satisfied, the plan will pay the stated percentages for Covered Expenses up to a calendar year maximum of $4,000 per person. This increase will apply to Covered Expenses incurred January 1, 2023, forward. This calendar year maximum does not apply to payments for orthodontics.

The lifetime maximum amount payable for covered orthodontic procedures is $5,500 for any Participant who commenced or will commence treatment on or after January 1, 2022. For all other Participants, the lifetime maximum is $3,000.

B. Calendar Year Deductible.

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

Covered Expenses incurred in the last three months of a year, which are applied toward the deductible, may be applied toward the deductible for the following calendar year. This deductible carry over does not, however, apply to the $60 family deductible.

C. Covered Services & Dental PPO Networks.

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

The Preferred Provider Organization for the Fee-For-Service Dental Plan is First Dental Health. Dentists who participate in the First Dental Health PPO & EPO networks have agreed to lower their charges for dental procedures. Using a Dentist in the First Dental Health network is voluntary; you do not have to switch from your current Dentist. But, by using a First Dental Health Dentist, you and the Trust should benefit from the reduced rates charged by First Dental Health Dentists. With out-of-network Dentists, you can be Balance Billed for charges that exceed the Allowed Amount.

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

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

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

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

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

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

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

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

- **Orthodontic Services.** The Fee-For-Service Dental Plan provides a separate benefit for orthodontic procedures. Orthodontic procedures are those that are associated with the straightening and realignment of the teeth. Covered services are payable at 90% of Covered Expenses if you have been enrolled in the plan for up to 24 months, and 100% of Covered Expenses if you have been enrolled in the plan for 24 or more months. Orthodontic procedures must be completed within a 24-month period; services incurred after the 24th month are not covered. All services are subject to the lifetime maximum described above in Section A. Services are deemed to be received as of the date of the banding or fitting of a retainer.

D. Limitations and Exclusions.

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

- Dental services to the extent they are covered by another group plan;

- Any treatment not ordered by a Dentist;

- Transportation charges;

- Expenses in connection with cosmetic procedures, including corrections for congenital malformations;

- Replacement of existing dentures, which are or can be made satisfactory;

- Replacement of lost or stolen prosthesis (fixed or removable) or their replacement within five years of their original installation, regardless of whether or not original installation occurred while covered under this plan;

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

- The cost of gold restorations;
- Special techniques involving precision dentures for personalization or characterization;
- Periapical and/or bitewing x-rays taken on the same day whose cost exceeds the allowance for a full mouth series;
- Porcelain crowns and molars;
- Services that are not necessary and essential or those for which there is a poor prognosis;
- Spacers where spaces have closed or crowns of erupting teeth have penetrated alveolar bone;
- Procedures on primary teeth that are about to fall out;
- Removal of important teeth that can be retained with endodontics;
- Charges for orthodontia billed prior to the date bands or appliances are placed; and
- Services in connection with orthognathic surgery.

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

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

If you or your Dependent incurs expenses for a hearing aid, which is certified by a Physician to be Medically Necessary, the Trust will pay for one hearing aid per ear every five years up to a maximum of $2,000 per device. This five-year period begins on the date on which the patient last incurred expenses for this benefit. There is no deductible.

B. Hearing Plan Network Provided by EPIC

Under the Fee-For-Service Hearing Aid Plan, you are not required to purchase your hearing aid(s) from any specific provider.

However, if you use the hearing plan network provided by EPIC (Ear Professionals International Corporation) to obtain your hearing aid(s), the following benefits will be available to you:

- You will receive an annual hearing exam at no charge;
- You will have access to brand-name hearing aids and related technology at published fixed fee pricing (a savings of 20-65% off MSRP);
- You will receive a one-year supply of batteries on all entry through advanced level hearing aids purchased (per device) or a five-year supply of batteries on all premium devices purchased (per device); and

- You will receive a 3-year warranty on purchased hearing aids that covers repairs at no cost and replacement due to damage or loss at a cost of $400.

To use the EPIC hearing plan, contact the EPIC Call Center at (866) 956-5400 from 6:00 am to 6:00 pm (PST), Monday through Friday, for more information and to make an appointment with a hearing counselor. You will need to identify yourself as a Participant in the Trust.

C. Limitations and Exclusions.

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

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

IX.
EXTRA MILE BENEFITS WELLNESS PROGRAM PROVIDED DIRECTLY BY THE TRUST

The Extra Mile Benefits Wellness Program, which is provided directly by the Trust, helps you stay well and prevent disease. Each eligible Employee or Retiree is allowed $2,000 of benefits per calendar year for him or herself and his or her eligible Dependents (i.e., $2,000per family). The following are covered under this program:

- Nutritional and food plan counseling when performed by a registered dietician;
- Alternative remedies, including non-FDA approved medications, homeopathics, vitamins, and mineral supplements, so long as prescribed by a Physician in writing. Books and consultation fees will not be covered;
- Exercise equipment, a Doctor's note recommending the use of Exercise Equipment is required to be submitted to the Fund when requesting reimbursement for the purchase of Exercise Equipment. Please note that the Fund will reimburse exercise equipment only at reasonable and customary rates (e.g., the reasonable cost of an exercise bike, as opposed to a Peloton);
- Acupuncture/Acupressure;
- Body Fat % Testing;
- Cryogenic Therapy;
- Float Therapy;
- Holistic Therapy;

- IV Therapy;
- Massages;
- Powders (Doctors Note Required);
- Pre and Post Workout Drinks;
- Sauna and Spa Services;
- Space Bar Recovery Services;
- 24 Hour Fitness Membership and 24 Hour Fitness Personal Training;
- Yoga & Pilates;
- 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; and
- Physical therapy and chiropractic services not covered through your medical plan.

The Trust will reimburse you directly and does not accept assignments. Simply submit your itemized bills with receipts, along with a prescription and any other required documents, 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 for reimbursement on a tax favored basis, the services must be performed by a licensed or recognized practitioner. Personal services must be related to a specific diagnosis, activity, or treatment, rather than for general health. To determine whether a service or treatment is covered, it is recommended that you contact the Administrative Office before the expense is incurred. Reimbursements which do not meet IRS guidelines are taxable as income. You should consider discussing your reimbursements from this Program with your tax preparer.

X.
THE VISION PLANS PROVIDED BY VSP

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

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

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

XI.
LIFE INSURANCE BENEFITS INSURED BY PRUDENTIAL

A. Life Insurance Benefit Amount.

If you are an Employee, a $50,000 life insurance benefit is payable to your beneficiary in the event of your death in accordance with the Prudential life insurance policy.

If you are a Retiree, a $50,000 life insurance benefit is payable to your beneficiary in the event of your death in accordance with the Fund's life insurance policy through The Prudential Insurance Company of America.

There is no life insurance coverage for Dependents. Payment of life insurance benefits by Prudential is subject to the terms, conditions, limitations, and exclusions stated in the governing Prudential policy documents. Contact the Administrative Office for a copy of the Booklet describing program benefits.

B. Beneficiary.

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

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

1. To your surviving spouse or registered domestic partner (as defined by Prudential), if none, then

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

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

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

5. To your executor or administrator.

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

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

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

The group Accidental Death and Dismemberment (AD&D) benefit, which is ~~a~~ fully insured by Prudential, is payable if an Employee or Retiree incurs a “covered loss,” as defined in accordance with the Prudential policy. The amount of the AD&D benefit payable by Prudential depends on the type of covered loss incurred. Contact the Administrative Office for a copy of the Prudential Policy here is no AD&D benefit coverage for Dependents. Payment of the AD&D benefits by Prudential is subject to the conditions, limitations, and exclusions stated in the Prudential policy.

XIII.
SUPPLEMENTAL ACCIDENT BENEFIT PROVIDED DIRECTLY BY THE TRUST

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

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

B. Enrolled in a Prepaid Medical Plan.

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

C. Applicable Services.

1. Medically Necessary services furnished by a Hospital for room and board and other services;
2. Medical and surgical treatment by a Physician;
3. Casts and dressings; and
4. Laboratory and X-ray examinations.

XIV.
EMPLOYEE ASSISTANCE PROGRAM PROVIDED BY OPTUM AND ANTHEM

A. Principal Benefits and Coverage.

Under Optum and Anthem Employee Assistance Program (“EAP”), you can be assessed and referred to Participating Practitioners (as defined below) who can help you and those in your household

resolve personal problems that can affect your health, family life, abilities, and desire to excel at work. Individuals enrolled in the EAP are entitled to up to 6 sessions with Anthem and 7 sessions with Optum without charge per incident per calendar year. The EAP benefit is available to enrollees in any of the Funds Medical plans.

B. What problems can an EAP handle?

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

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

C. Choice of Physicians and Practitioners

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

If you are in need of services, Optum and Anthem must pre-authorize a referral to a Participating Practitioner.

You must call Optum at 1-866-248-4096 or Anthem at 1-800-999-7222 to be referred, and prior authorization is always required to obtain EAP services. Anthem and Optum will only refer you or those in your household to one of its Participating Practitioners.

If you have questions regarding any of Optum or Anthem's Participating Practitioners, or you would like a list of Participating Practitioners located within your geographic area, you can call Optum at 1-866-248-4096 and Anthem at 1-800-999-7222. You may also view a list of Participating Practitioners on Optum's website at www.liveandworkwell.com (access code MTATCU) and Anthem's website at www.anthemEAP.com (access code TCU).

Anthem and Optum's-roster of Participating Practitioners is subject to change. Although Anthem and Optum update their websites on a weekly basis so that the information includes only practitioners currently available to service members, Anthem and Optum cannot guarantee the initial or continued availability of any particular Participating Practitioner.

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

A. Non-Assignment of Benefits

With the exception of medical benefits assigned to a Hospital or Physician, no Employee, Retiree, or Dependent shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber,

pledge, commute, or anticipate any benefit payment hereunder. Benefits hereunder shall not be subject to levy or execution or attachment or garnishment.

B. Facility of Payment

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

C. Doctor Examination During Pendency of Claim

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

D. Rights to Receive and Release Necessary Information

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

E. Excessive Charges

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

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

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

F. Services Excluded from Coverage

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

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

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

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

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

5. Charges for services or supplies in excess of Covered Expenses (for example, charges that exceed Allowed Amounts as determined by the Fund) or a benefit maximum;

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

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

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

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

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

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

12. Vitamins or dietary supplements, except as prescribed and covered under the Extra Mile Wellness Program;

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

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

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

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

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

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

G. For Persons Eligible for Medi-Cal.

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

H. For Persons Disabled by HIV/AIDS

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

XVI. COORDINATION OF BENEFITS

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

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

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

Here is how the Trust determines which plan is primary:

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

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

1. The plan covering the person as an employee ~~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; and

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; and

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

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

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

If you are covered as an Employee under the Trust's Fee-for-Service Medical or Dental Plan and as a dependent under a pre-paid/HMO plan sponsored by your spouse's employer, you may receive treatment from either your own Physician/Hospital under the Trust's Fee-For-Service Plan or from the pre-paid/HMO plan Physician/Hospital. If you receive treatment through the pre-paid/HMO plan, the Trust will only reimburse you for the amount of Copayments paid to the pre-paid/HMO plan.

XVII.
THIRD PARTY LIABILITY

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

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

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

Notice of the rights of the Trust, including the above-mentioned lien rights, may be filed by the Trust with any person having a material interest in the existence of such rights, including, but not limited to, the court in which an action is filed.

If a participant fails at any time, as determined by the Trustees, to comply with the requirements and obligations of this Article, the Trustees may, in their sole and absolute discretion, offset all or any portion of the Trust's lien for reimbursement against any benefits that would otherwise be provided by the Trust to the participant, as well as to any Dependent (in the case of noncompliance by an Employee or Retiree) or to the Employee or Retiree (in the case of noncompliance by a Dependent).

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.

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 factors including, but not limited to, costs incurred by the participant, (including attorney's fees and costs of litigation incurred to procure the recovery), loss of earnings, out-of-pocket expenses, anticipated unreimbursed future medical expenses, the permanence of the injuries, and the impact of the same on future employment.

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

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

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

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.

XVIII.
WORKERS' COMPENSATION

The Trust does not provide benefits for any Sickness, Injury, disease, or other condition (collectively referred to in this Article as "injury") if the expenses for the treatment of such injury are covered by workers' compensation or occupational disease law.

If you or your enrolled Dependent (referred to in this Article as "the injured participant") experience a work-related injury (including but not limited to being injured while at work), the injured participant should file a workers' compensation claim with his or her employer. If the employer denies the workers' compensation claim, the injured participant must appeal the denial through his/her employer's workers' compensation carrier. The injured participant's appeal must be filed with a Division of Workers' Compensation District Office, also known as the Workers' Compensation Appeals Board office, as an Application for Adjudication.

In order for a claim related to a work-related injury to be considered for payment by the Trust, the injured participant must submit a copy of (1) the denial notice from his or her employer, and (2) the Application for Adjudication, to the Administrator. The Trust will file a Notice and Request for Allowance of Lien with respect to any expenses for the treatment of any work-related injuries alleged to be covered under workers' compensation or occupational disease law. The Trust's Notice and Request for Allowance of Lien will be issued to the injured participant for signature. Upon receipt of the injured participant's signature for the Trust's Notice and Request for Allowance of Lien, any pending claims related to the injured participant's work-related injury will be processed and the Trust will seek satisfaction of its lien through the Workers' Compensation Appeals Board.

XIX.
MEDICARE

A. Employees and Dependent Spouses Over Age 65.

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

B. Reimbursement of Medicare Part B Premium by MTA.

The MTA has a program to reimburse Retirees for a portion of their monthly Medicare Part B premium. To obtain reimbursement, you must submit to the MTA a Medicare reimbursement application, along with proof that you paid Medicare Part B premium payments. If you qualify, the MTA will make payments on a quarterly basis each January, April, July, and October. Retroactive payments will be made only to the beginning of the quarterly periods described above, in which your application was received. Reimbursement of Medicare Part B premiums is not paid or administered by the Trust. MTA is solely responsible for program rules and eligibility, as well as funding, for Medicare Part B reimbursement.

XX.
CLAIMS AND APPEALSPROCEDURES

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

A. Initial Claim for Benefits.

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

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

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

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

A claim denial also includes a denial of a Claim pertaining to the protections of the No Surprises Act, codified at Title II, Division BB of the Consolidated Appropriations Act.

B. Appeal Procedure.

If you are not satisfied with the action taken on your initial claim for benefits, you may appeal to the Board of Trustees for reconsideration of the decision and must do so as a condition precedent to judicial review. The appeal must be received by the Administrative Office within 60 days from the date you received notice of the initial benefit determination from the Administrative Office. The appeal must be in writing, should state all the reasons for disagreement with the decision, and include any additional facts regarding the claim for benefits which you wish to be made known in clear and concise terms.

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

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

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

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

respond within the applicable period, the appeal application will be deemed denied.

C. NO SURPRISE ACT APPEAL.

Claimant may also file an Appeal if the Claimant alleges that the Plan improperly denied him the protections of the No Surprises Act, codified at Title II of Division BB of the Consolidated Appropriations Act.

DEFINITIONS

1. **Accident** means an unexpected happening, that results in the bodily injury of a Participant. The term does not include: (1) an attempt at suicide or an intentionally self-inflicted injury, disease, or infirmity; or (2) bacterial infections, except those which occur with and through a cut or wound at the time of an Accident.

2. **Allowed Amount** means the amount the Trust allows for covered services or supplies that are provided by non-PPO providers. The Allowed Amount, as determined by the Plan Administrator, or its designee, is the lesser of (1) the provider's actual billed charge or (2) the dollar amount that will be allowed for the Medically Necessary service or supply. You are responsible for your cost sharing portion (Coinsurance, Copayment) of the Allowed Amount, as well as any charges that exceed the Allowed Amount.

3. **Balance Billing (or Balance Billed)** means a bill from a health care provider to a patient for the difference between the provider's actual billed charges and the Plan's Allowed Amount. This happens most often when you use a non-PPO provider. Generally, you can avoid being Balance Billed by using PPO providers. Balance billing is not covered by this Plan.

4. **Copayment (or Copay)** means a fixed amount (for example, $5) that you are responsible for paying, usually at the time of service, for a covered service or supply. Note that if you use a non-PPO Provider, in addition to your Copayment, you may be responsible for charges that exceed the Allowed Amount.

5. **Coinsurance** means your share of the cost of a covered service, calculated as a percentage (for example, 20%), of the Covered Expense. Generally, you pay Coinsurance plus any deductibles you owe, and any Coinsurance you pay counts towards your Out-of- Pocket Maximum.

For example, if the Trust's Covered Expense for an office visit is $100 and you've met your deductible, your Coinsurance of 20% would be $20. The Trust pays the rest (80%) of the Covered Expense.

Note that if you use a non-PPO provider, in addition to your Coinsurance, you may be responsible for charges that exceed the Allowed Amount.

6. **Contract Rate** means the amount the PPO has negotiated with health care providers for medical services. With respect to prescription drugs obtained from a Sav-Rx network pharmacy, the Contract Rate is the price negotiated for the Trust by Sav-Rx for the prescription drug.

7. **Covered Expenses** are either (1) the Contract Rates for PPO providers or (2) the Allowed Amount for non-PPO providers., for the services and supplies listed under Article V, Section C and Article VII, Section C, which are certified by the attending Physician or Dentist and determined by the Trust to be Medically Necessary for the care and treatment of an Injury or Sickness and are not otherwise excluded under Article V, Section D or Article XV, Sections E and F. See pp. 16- 17 and 28 to 30.

8. **Dentist** means a person licensed to practice Dentistry in the state in which he renders treatment. It does not include the spouse, child, sibling, or parent of the Employee, Retiree, or their Dependents.

9. **Dependent** is a person described in Article II. ("Eligibility Rules"), Section A. ("Dependents of Full Time Employees and Retirees ('Dependents')").

10. **Drug or 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.

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

12. **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.

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

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

- Considered to be experimental or investigational by any governmental agency or subdivision, including but not limited to the U.S. Food and Drug Administration, the U.S. Office of Health Technology Assessment, or the U.S. Health Care Financing Administration (HCFA) in its Medicare Coverage Issues Manual; or
- Not covered under Medicare reimbursement laws, regulations, or interpretations; or
- Not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that:
- The medical procedure, equipment, treatment or course of treatment, or drug or medicine is under investigation or is limited to research; or
- The techniques are restricted to use at centers that are capable of carrying out disciplined clinical efforts and scientific studies; or
- The procedures are not proven in an objective way to have therapeutic value or benefit; or
- The procedure or treatment's effectiveness is medically questionable.

15. **Full Time Employee** means an employee employed on a full-time basis by the Los Angeles County Metropolitan Transportation Authority and working under the collective bargaining agreement with TCIU Lodge 1315 requiring contributions to this Trust. For purposes of eligibility as a Retired Employee only, Full Time Employee also includes service as an employee employed on a full-time basis by the MTA while working under a collective bargaining agreement with the Amalgamated Transit Union ("ATU") or with the Sheet, Metal, Air, Rail and Transportation Union ("SMART"), formerly known as the United Transportation Union ("UTU").

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

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

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

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

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

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

18. Services and supplies are **Medically Necessary** if such service or supply is determined by the Trust to be:

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

- Not experimental, educational, or investigational;

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

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

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

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

19. **Mental Health Disorder** is an illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

20. **Non-PPO Provider** means a Physician, Dentist, or other health care provider who does not participate in the Plan's network of providers (i.e., is not a PPO Provider).

21. **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.

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

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

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

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

26. **Preferred Provider Organization (PPO)** means an organization that has contracted with health care providers to form a network of providers (e.g., Hospitals, laboratory, radiology facilities, Physicians, Dentists, and/or other providers of health care services) to provide services to Plan Participants at negotiated rates. The health care providers that are in the PPO network are called "PPO Providers."

27. **Retired Employee or Retiree** means any person who, by reason of his retirement from active employment with the MTA, meets the eligibility requirements for retirees established and amended from time to time by the Trust.

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

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

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

31. **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 the same or similar services, treatments, or supplies to persons: (1) in the same area; and (2) whose Sickness is comparable in nature and severity. The term "area" means a zip code, county, or other geographic area as necessary, which constitutes a representative cross-section enabling the determination of usual charges.

XXI.
INFORMATION ABOUT THE PLAN

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

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

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

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

Board of Trustees
Transportation Communications International Union
Los Angeles County Metropolitan Transportation Authority
Health and Welfare Trust Fund
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906
(562) 463-5090
(800) 427-5342

The administrative functions of the Plan are performed by:

Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906
(562) 463-5090
(800) 427-5342

Name, Titles, and Addresses of the Trustees. As of February 2024, the Trustees of this Plan are:

Union Trustees

Michael Winston
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles CA 90017-1906

Joshua Ott
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Matt Hollis
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Freddie Flores (Alternate)
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Michael Yanuaria (Alternate)
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Bridgette Travenia (Alternate)
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Metro Trustees

Debra Avila
Chief Vendor/Contract Management Officer
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-8-1
Los Angeles, California 90012-2952

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

Esther Reed-Murphy
LA County Metropolitan Transportation Authority
One Gateway Plaza, 99-14-2
Los Angeles, California 90012-2952

Kathy Knox (Alternate)
Metropolitan Transportation Authority
One Gateway Plaza, Mail Stop 99-17-1
Los Angeles, California 90012-2952

Provider Contact Information

United Concordia
DHMO customer service number: (866) 357-3304

DHMO network: DHMO Concordia Plus
Address: 21700 Oxnard Street, Suite 500, Woodland Hills CA 91367
DHMO claims address: United Concordia Dental Claims, P.O. Box 69422, Harrisburg, PA 17106

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

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

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

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

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

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

Ear Professionals International Corporation (EPIC)
Customer service number: (866) 956-5400

Optum (EAP) Customer Service Managed Health Network (EAP) Customer service number: 1-866-248-4096 **Address**: 11000 Optum Circle, Eden Prairie, MN 55344

Anthem (EAP) Customer service number: 1-800-999-7222 Address:

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

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

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

Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor Los Angeles, California 90017-1906
The service of legal process may also be made upon any Plan Trustee.

A. Collective Bargaining Agreement and Source of Contributions. The MTA makes contributions to the Plan on behalf of all eligible Employees, Retirees, and their eligible Dependents. In addition, Employees make monthly participant contributions, and Retirees make quarterly participant contributions, to the Plan. The amount of these contributions is determined by the collective bargaining agreement between the MTA and the Union.

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

C. Trust. The Plan's assets and reserves are held in trust by the Board of Trustees of the Transportation Communications International Union - Los Angeles County Metropolitan Transportation Authority Health and Welfare Trust Fund.

D. Identity of Providers of Benefits. Benefits provided under the Fee-For-Service Medical Plan, the Fee-For-Service Dental Plan, the Fee-For- Service Hearing Aid Plan, the Extra Mile Benefits Wellness Program, and the Supplemental Accident Benefit are self-funded and provided directly from the Trust itself. Prepaid medical benefits are provided by Kaiser Permanente and UnitedHealthcare. Prepaid dental benefits are provided by United Concordia. Prepaid vision benefits are provided by VSP. EAP benefits are provided by Optum and Anthem. Life insurance and accidental death and dismemberment benefits are provided by Prudential. The complete terms of the prepaid medical plans are set forth in the Kaiser Foundation Health Plan Group Hospital and Medical Service Agreement and the UnitedHealthcare Service Agreement. The complete terms of the prepaid dental plan are set forth in the United Concordia Service Agreement. The complete terms of the prepaid vision plan are set forth in the VSP Service Agreement. The complete terms of the EAP benefits are set forth in the Optum and Anthem Service Agreements. The complete terms of the life insurance and accidental death & dismemberment benefits are set forth in the Prudential Life Insurance Service Agreement.

E. 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.

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

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

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

The Trustees reserve the right to amend, modify, or discontinue all or part of this plan at any time and for any reason.

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE PPO/Out-of- Network (OON)**	**KAISER (Network Providers Only)**	**UNITED HEALTHCARE (Network Providers Only)**
Deductible	$50 per person; $150 family maximum per calendar year; additional $250 per Hospital confinement at OON Hospital	None	None
Lifetime Maximum	None	None	None
Calendar Year Maximum	None	None	None
Out-of-Pocket Maximum	$1,000 per person	$1,500 per person; $3,000 per /family	$1,000 per person; $3,000 per /family
DESCRIPTION OF BENEFITS	**FEE-FOR- SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Hospital Inpatient (Facility Fees)	PPO –100% of Contract Rate OON-80% of Allowed Amount	No charge	No charge

Room and Board	PPO -100% of Contract Rate OON – 80% of	No charge	No charge
Intensive Care	PPO - 100% of Contract	No charge	No charge
Miscellaneous	PPO - 100% of Contract	No charge	No charge
Outpatient (Facility Fees)	PPO -100% of Contract OON - 80% of	Facility - $5 Copay;	No charge

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR- SERVICE**	**KAISER**	**UNITED HEALTHCARE**
Physician Fees	**TRUST PAYS**	**YOU PAY**	**YOU PAY**
Inpatient	PPO - 80% of Contract Rate	No charge	No charge
Outpatient	PPO - 80% of Contract Rate	$5 Copay per procedure	No charge
Hospital Visits	PPO - 80% of Contract Rate	No charge	No charge
Office Visits	PPO - 80% of Contract Rate	$5 per visit	$5 per visit
X-ray & Laboratory Service	PPO - 80% of Contract Rate	No charge	No charge

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

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR- SERVICE**	**KAISER**	**UNITED HEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Physical Therapy	PPO - 80% of Contract Rate OON - 80% of Allowed Amount	$5 per visit outpatient	$5 per visit
Chiropractic Services	PPO - 80% of Covered Expenses OON - 80% of Allowed Amount	Not covered	Not covered
Acupuncture	PPO - 80% of Covered Expenses OON - 80% of Allowed Amount	$5 per visit	Not covered

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

SCHEDULE OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	**FEE-FOR- SERVICE**	**KAISER**	**UNITEDHEALTHCARE**
	TRUST PAYS	**YOU PAY**	**YOU PAY**
Prescription Drugs	PPO (Sav-Rx) - 80% of Contract Rates OON – Not Covered;	$5 per prescription for up to a 100 days' supply	$5 per prescription

SCHEDULE OF DENTAL BENEFITS		
DESCRIPTION OF BENEFITS	**FEE-FOR-SERVICE* (First Dental Health)**	**PREPAID DENTAL (United Concordia)**
Deductible	$20 per person; $60 maximum per family per calendar year	None
Calendar Year Maximum	$2,500 per person for non-orthodontic charges	None
Orthodontic Lifetime Maximum	$5,500 per person	None
	TRUST PAYS	**YOU PAY**
Diagnostic, Preventive Restorative, Prosthetic, Prosthodontics and Oral Surgery Enrolled in Plan -		
- First 12 months	90% of Covered Expenses	Various Copayments
- 13th month and after	100% of Covered Expenses	Various Copayments
Orthodontic** Enrolled in Plan		
- First 24 months	90% of Covered Expenses	$1,500 Child Ortho $2,000 Adult Ortho
- 25th month and after	100% of Covered Expenses	Fully Covered

*The Fee-For-Service Dental Plan has three levels of benefits. You have the lowest out-of-pocket expense when you use a participating Dentist in the First Dental Health EPO network, the next lowest out-of-pocket expense when you use a participating Dentist in the First Dental Health PPO network, and the highest out-of-pocket expense when you use an out-of-network Dentists. A list of participating Dentists in the First Dental Health EPO and PPO networks is available at www.firstdentalhealth.com.

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

SCHEDULE OF VISION BENEFITS	
DESCRIPTION OF BENEFITS	
The VSP Signature Plan	The VSP Signature Plan, provides, each calendar year: 20% off an eye exam and a complete pair of prescription glasses and 15% off the contact lens exam; A $550.00 allowance for an exam, frame, lenses, lens enhancements, and contacts; 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last exam; Average 15% off the regular price or 5% off the promotional price of laser vision correction provided by contracted facilities. For Participants enrolled in a prepaid medical plan, the cost of the eye exam may be spared from the allowance if the eye exam is administered through the prepaid medical plan. Part Time Employees are only eligible for the VSP Signature Plan.

The VSP Choice Plan	The following vision coverage is provided for a $10 Copayment per calendar year when using a VSP network provider.
Exam (once every 12 months)	100% of allowable charges
Prescription Glasses Lenses (once every 12 months) Frames (once every 12 months) **-OR-** Contact Lens Care (once every 12 months)	100% of allowable charges 100% of allowable charges $550.00 maximum frame allowance; 20% off the amount over the allowance $350.00 allowance for Contact Lenses. Examinations and fittings will have a separate $60.00 Fee.
Glasses and Sunglasses	Average 20-25% savings on all non- covered lens options; 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last eye exam
Contacts	15% off cost of contact lens exam (fitting and evaluation)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotion price. Discounts only available from contracted facilities.

Out-of-Network Reimbursement Amounts:	Exam -– up to $43.00 Single vision lenses – up to $26.00 Lined Bifocal lenses – up to $43.00 Lined trifocal lenses – up to $60.00 Frames – up to $40.00 Contacts – up to $100.00

SCHEDULE OF HEARING AID BENEFITS	
DESCRIPTION OF BENEFITS	**COVERAGE**
	TRUST PAYS
Hearing Aid	$2,000 per device; and limited to one device per ear every 5 years.

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