Montebello Teachers Association Retiree Supplemental Health Plan for Retired Employees

Plan Document and Summary Plan Description

January 1, 2026

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Introduction

The Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan") is a type of plan called a VEBA, short for Voluntary Employees' Beneficiary Association (VEBA), that is tax exempt under section 501(c)(9) of the Internal Revenue Code. The Plan is not an HSA or an FSA.

In the past year, Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan" or sometimes referred to as "Retiree Plan" or the "Trust") has undergone many changes.

On April 30, 2025, all contributions to the Plan ceased. As a result, the Board of Trustees implemented a temporary suspension of benefits while it conducted an actuarial study. Ultimately, given that no future contributions will come into the Plan, the Board of Trustees of the Plan ("Trustees") made the difficult decision to begin winding down the Plan.

On September 18, 2025, the Trustees approved the final Actuarial Report, concerning the future allocation of available Plan benefits. This Actuarial Report was mailed to you on September 25, 2025. The Actuarial Report details how these calculations were made and is also available on the Trust Office's website at **https://coastbenefits.com/your-plan/montebello-teachers-association-3n/**. You may also request in writing a paper copy of the Actuarial Report at no charge from the Trust Office.

The Plan has been redesigned so that participants can receive their Allocated Amount through the payment of Plan benefits. This booklet is both the Plan Document and the Summary Plan Description (hereafter "SPD"), and is an amendment and restatement of the Montebello Teachers Association Retiree Supplemental Health Plan dated January 2023. It serves to describe the rules of the Plan, including benefits available under the Plan. Ultimately, there will be no remaining Plan assets, and the Plan will be dissolved.

Participants must submit a claim for Covered Expenses with all required documentation by the annual claims deadline, which is March 31st, i.e., three (3) months after the end of the calendar year in which the Covered Expense was paid.

This SPD may be amended from time to time. You will be sent a Summary of Material Modifications, explaining material changes that result from any such amendment. The benefits described in this booklet are not vested and may be modified, amended, reduced or terminated at any time for some or all Participants (and Beneficiaries) by the Board of Trustees in accordance with the terms of the Trust Agreement.

The Board of Trustees has the sole and exclusive authority to construe, apply, and interpret the Plan and all rules relating thereto, including the rules governing eligibility for and entitlement to benefits. Employees of the Trust Office and Montebello Teachers Association (MTA) have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by employees of the Trust Office or the MTA are not binding upon the Board of Trustees.

For Retirees Age 67+ Who Received Benefits from This Plan in 2025:

If you are a Covered Retiree who was in pay status with the Plan at any time in 2025 (i.e., you were age 67 or older and received reimbursements of your CalPERS premiums from this Plan in one or more months of 2025), your monthly benefits were suspended effective July 1, 2025.

If you have an Allocated Amount with the Plan, the Plan will reimburse the monthly CalPERS premiums you paid for the months of July through December of 2025, up to your Allocated Amount. As described in Article 5, section 1, the Plan will reimburse by a deposit made to your designated account. Once your Allocated Amount has been disbursed in full, no further benefits will be payable from the Plan, and you will cease to be a Plan Participant.

The Plan intends to make these reimbursements beginning in December 2025, without you having to submit a claim or take any further action.[1]

[1] The Plan will issue these reimbursements as long as reports provided by CalPERS show that you paid premiums for one or more months during the period July through December 2025.

Article 1: Definitions

Whenever the following words or phrases are capitalized in this SPD, they shall have the meaning set forth in this Article, unless the context clearly indicates otherwise.

Active Plan. The term "Active Plan" means the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees, which is effective January 1, 2026.

Allocated Amount. Each Participant's Allocated Amount as of January 1, 2026, is 44.93% of: the Participant's estimated total contributions paid into the Plan, minus the estimated total premium reimbursements (if any) that the Participant has already received from the Plan.[2] The Allocated Amount does not earn interest and is not credited with any investment earnings. Retirees with an Allocated Amount of $0 will not be eligible for any further benefits from the Plan. For more detail on Allocated Amounts, please see Article 4, section 1.

A Participant can have only one Allocated Amount. If eligible for benefits under both the Retiree Plan and the Active Plan, the Participant will be in the Retiree Plan, if the Participant is not working for the District.

Beneficiary. The term "Beneficiary" refers to any individual designated by a Participant to receive the Participant's death benefit.

Board of Trustees. The term "Board of Trustees" or "Trustees" is the Board of Trustees of the Plan, compromised of the persons designated pursuant to the terms of the Second Restated Agreement and Declaration of Trust Providing for the Montebello Teachers Association Retiree Supplemental Health Plan (hereafter "Trust Agreement").

CalPERS. The term "CalPERS" means California Public Employees Retirement System.

CalSTRS. The term "CalSTRS" means the California State Teachers Retirement System.

Children (or Child). The term "Child" or "Children" means a natural child, legally adopted child, or stepchild of the Participant, who is under age 26. A Disabled Child of any age, who is legally dependent upon the Participant, also qualifies as a Child, for so long as the Child is determined to be permanently and totally disabled by the Social Security Administration. Procedures governing qualified medical child support orders can be obtained, free of charge, from the Trust Office.

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[2] Participants' estimated total contributions and estimated total premium reimbursements are determined and set forth in the Actuarial Report, which is in Appendix A to this SPD. The estimated total contributions that a Participant has paid into the Plan is the Average Cumulative Contributions amount shown in column (A) of Chart 1 or 2, as applicable, for that Participant. For Participants who have previously received premium reimbursements from the Plan, the estimated total premium reimbursements is the Average Cumulative Premium Reimbursement amount in column (B) of Chart 2 that is applicable to that Participant.

Contributory Service. The term "Contributory Service" means periods of full-time employment with the District during which contributions were made to the Plan and dues were paid to the MTA. In order to be eligible for benefits under the Plan, a Participant must have retired from the District on or before June 30, 2025, and satisfied the rules to be eligible for reimbursement of Covered

Expenses, as set forth in Article 2 of this Plan, including:

1) having earned fifteen (15) years or more of Contributory Service, provided the five (5) years of employment with the District immediately preceding retirement, are consecutive (subject to any eligible Break In Service exceptions discussed below), and

2) paid all contributions owed to the Plan, and paid union dues owed to MTA, during all periods of active service with the District through April 30, 2025.

Covered Expense. The term "Covered Expense is defined in Article 4, section 3.

Covered Retiree. The term "Covered Retiree" means a former employee who retired from the District under the California State Teachers Retirement System (CalSTRS) on or before June 30, 2025, and who, at the time of retirement from the District, was at least 55 years old and satisfied all of the eligibility requirements of Article 2, sections 1 and 2 of the Plan, except that return to employment with the District, in any capacity, will disqualify the Covered Retiree from eligibility for benefits and participation in this Retiree Plan. Instead, you will be able to obtain the remainder of your Allocated Amount under the Active Plan, upon satisfying the conditions of that plan. A former employee who returns to employment with the District, in any capacity, is not a Covered Retiree while employed by the District.

Dependent. The term "Dependent" means the Participant's Child(ren) and lawful spouse (including a same-sex spouse). Due to the costs of compliance with federal tax regulations and the potential taxation of such benefits, the Plan does not reimburse expenses incurred by domestic partners.

District or MUSD. The term "District," as defined at Section 2.07 of the Trust Agreement, means the Montebello Unified School District.

Early Retirement Option. The term "Early Retirement Option" means the option available to an employee who is 55 to 59 years old, has completed 15 years of service with the MUSD and who may choose to work 20 days per year while retired from the MUSD. This arrangement is permitted for 5 consecutive years prior to age 60.

ERISA. The term "ERISA" means The Employee Retirement Income Security Act of 1974. This law gives Plan Participants certain rights as discussed in the ERISA section.

Medicare. The term "Medicare" means the hospital and medical insurance program administered by the Federal government through the Social Security Administration. Medicare has four (4) parts: Part A is the in-patient hospital program; Part B is the doctors and medical service program; Part C covers the prepaid Medical Advantage plans; and Part D is the prescription drug program.

Member. The term "Member" means a bargaining unit member who paid the dues amount established by the MTA for full-time employees through April 30, 2025.

MTA or Association. The term "MTA' or "Association" means the Montebello Teachers Association.

Non-Member. The term "Non-Member" means an individual who, as of May 1, 2025, is not a Member of MTA and does not pay union dues. A Non-Member has no Allocated Amount.

Participant. The term "Participant" means any Covered Retiree (as defined above) who is eligible for benefits under the Plan, in accordance with Article 2, sections 1 and 2 of this Plan, and has not had a loss of Eligibility under Article 3 of this Plan.

Permanent Employee. The term "Permanent Employee" generally refers to any certificated employee who has completed two full years of probationary service in a vacant position within the District, thereby acquiring permanency.

Plan (or Retiree Plan). The term "Plan" or "Retiree Plan" means the Montebello Teachers Association Retiree Supplemental Health Plan.

Plan Year. The term "Plan Year" means the fiscal year of the Plan, which runs from September 1 to August 31. The term "Plan Year" has no relevance for claims submission deadlines.

Trust Fund. The Trust Fund means all monies and assets of any kind which belong to or are a part of this trust estate of the Plan.

Trust Office. The term "Trust Office" means the office of the third-party administrator (Coast Benefits) contracting with the Plan to provide the day-to-day Plan administration.

Article 2: Eligibility

Section 1: Eligibility to Participate in this Plan (requires 15 years of Contributory Service)

To be eligible for benefits from this Plan, you must be a Covered Retiree who retired from the District under CalSTRS on or before June 30, 2025, and who, at the time of retirement from the District, was at least 55 years old and had earned at least 15 years of Contributory Service with the District, **including at least five (5) consecutive years immediately prior to retiremen**t, during which time you:

1) worked as a full-time employee of the District; and

2) paid member dues (including Plan contributions) to MTA; and

3) were employed in a position covered under the MTA/MUSD collective bargaining agreement; and

4) were a member in good standing with MTA through April 30, 2025.

Each year that you met these conditions, you received one year of Contributory Service.

You are eligible for benefits from the Plan only if you meet the above conditions and have an Allocated Amount (or a portion of an Allocated Amount) that has not yet been reimbursed by the Plan. Additionally, a Covered Retiree who returns to employment with the District, in any capacity, will cease to be a Participant in this Plan and will not be eligible for benefits from this Plan. Such Covered Retirees will be able to obtain their Allocated Amount (or portion thereof) under the Active Plan, upon satisfying the conditions of that plan.

Participants who permanently ceased to pay dues to MTA prior to April 30, 2025, or permanently ceased to make contributions to the Plan prior to attainment of age 67 (or April 30, 2025, if earlier) are no longer Participants and are not eligible for benefits from the Plan. For more detail, see Article 3, section 1 of this SPD.

Section 2: Eligibility for Reimbursement Benefits

The Plan only reimburses expenses that qualify as Covered Expenses, as defined below. Reimbursements for Covered Expenses are available only to Covered Retirees who are eligible for benefits (as described in section 1 of this Article 2), and satisfy each of the following conditions:

1) have qualified for CalSTRS retirement benefits or have maintained special management eligibility and have qualified for MUSD retirement health benefits as outlined under the collective bargaining agreement; and

2) have been covered continuously under the MUSD retiree health plan from the date of retirement from MUSD until the earlier of: April 30, 2025, or the age at which the MUSD retirement health coverage terminates (age 67); or

    a) have been a Plan Participant from the beginning of full-time employment with MUSD (or from September 1, 1986, if full-time employment with MUSD started before then) until the time of retirement from the District or paid retroactively for the time period missed; or

    b) if not a full dues paying member, you must have converted from Non-Member status to full membership status and paid retroactively for the non-membership period.

3) have retired under CalSTRS; and

4) have purchased Part B of Medicare (if eligible) and enrolled in Part A, if eligible (or petitioned for a waiver for Part A); and

5) you must maintain an account in any qualified financial institution (all fees charged by the qualified financial institution must be paid by the Participant and are not included in the reimbursement benefits offered by this Trust); and

6) have an Allocated Amount, the entirety of which has not yet been reimbursed.

Section 3: Examples

Example No. 1 – Early Retirement

Michelle is a member who has reached age 55, and, based on her service with the MUSD, Michelle is eligible for early retirement. During her time with the MUSD, Michelle has been a member of the MTA.

While on the Early Retirement Option with MUSD, Michelle is able to continue her health care coverage through the MUSD. Her premium for that coverage is deducted from her CalSTRS distribution and reimbursed by MUSD to her designated account. The amount that MUSD will reimburse will be no more than the MUSD rate for active employees. If the premium for Michelle's coverage costs more than the MUSD allotment, Michelle must pay the difference.

Effective January 1, 2026, if Michelle's coverage costs more than the MUSD allotment, Michelle may submit a claim to the Plan to be reimbursed for the difference, subject to the rules of the Plan and the availability of her Allocated Amount. In addition, to the extent Michelle has out-of-pocket medical costs that qualify as Covered Expenses (such as Medicare Part B and Part D premiums, copayments or coinsurance for doctor's appointments or hospital stays) she can also submit a claim to be reimbursed by the Plan for those expenses, subject to her Allocated Amount.

At age 67, MUSD does not contribute at all toward the cost of Michelle's coverage.

Example No. 2 – Regular Retirement

Henry retired in 2023 and received premium reimbursements from the Plan through June 30, 2025. His benefits were then suspended. Effective January 1, 2026, if Henry's out-of-pocket medical costs qualify as Covered Expenses (such as Medicare Part B premiums, copayments and coinsurance for doctor's appointments, hospital stays, or prescription drugs) he can submit a claim to be reimbursed by the Plan for those expenses, subject to his Allocated Amount.

Section 4: Non-Members

Prior to April 30, 2025, Non-Members were eligible to join the Montebello Teachers Association and qualify for retiree benefits under the Plan, if the following conditions were met:

1) They elected to become a dues-paying member of the MTA continuously without interruption since first becoming a member and for no less than five consecutive years prior to retirement; and

2) They paid the required monthly dues (including Plan contributions) to the MTA for a minimum of 15 years and for at least five consecutive years immediately prior to retirement, or they paid such dues and contributions from the date they joined the MTA through April 30, 2025; and

3) They made back payments to the Plan for the total amount of unpaid/missed contributions, plus a per annum interest rate determined by the Board of Trustees, at the time of the back payment, which was no less than 7% interest per annum. All back payments, including interest, were paid to the Plan.

Section 5: Retired Non-Members

Effective May 1, 2025, a retired Non-Member who, immediately prior to his or her retirement from the MUSD, paid union dues (including Plan contributions) during the entire period he or she was employed by the District, and who, at or after retirement from the District, inadvertently ceased paying MTA dues and/or Plan contributions, will be eligible for an Allocated Amount, if each of the following conditions is satisfied:

1) The retired Non-Member otherwise satisfies the eligibility requirements for Retiree benefits as set forth in Article 2, section 1 of this SPD; and

2) The retired Non-Member pays the Plan for all missed contributions in a lump sum with interest, from the date the retired Non-Member ceased paying Plan contributions through April 30, 2025, or through the date the Non-Member reached age 67, if earlier. The interest to be paid is 7% per annum.

3) The retired Non-Member pays all missed Union dues to the MTA (at the retiree rate) though April 30, 2025.

A retired Non-Member will be considered to have inadvertently ceased paying MTA dues and/or Plan contributions if it is determined that: (1) the retired Non-Member did not know and was not informed that he or she was required to continue paying union dues after retirement; or (2) the retired Non-Member did not know and was not informed that he or she was required to pay contributions to the Plan through age 67 (or until April 30, 2025, if earlier).

Article 3: Loss of Eligibility

Retirees in the Plan lost Participant status (i.e., are no longer a Participant) and will not be eligible for any benefits from the Plan if, prior to April 30, 2025, they:

1) left employment with the District permanently, prior to retiring from the District; or

2) discontinued membership with the MTA while employed by the District or during retirement; or

3) did not pay all contributions due to the Plan through age 67 or until April 30, 2025, if earlier.

In addition to the above:

1) If you return to employment with the District, in any capacity, you will not be eligible for benefits from this Plan. (However, you may be eligible to receive benefits under the terms of the Active Plan, upon satisfying the conditions of that plan. Please contact the Trust Office for more information).

2) A Participant who dies on or after June 1, 2025, will cease to be a Participant as of the date of death, and no further benefits will be payable from the Plan, except that if the Participant died without having received his or her full Allocated Amount, a death benefit of the remainder of the Allocated Amount will be paid to the Participant's surviving Beneficiary and/or Spouse, as applicable, as described in Article 4, section 5.

3) A Participant who died prior to June 1, 2025, is no longer a Participant, but his or her Beneficiary may be eligible for death benefits from the Plan, in accordance with Plan provisions applicable to deaths that occurred between January 1, 2023 and May 31, 2025, if a claim for such benefits is timely submitted by May 31, 2026, in accordance with the Article 4, section 5 (Death Benefits) and the Claims and Appeals Procedures in Article 6 of this SPD.

4) There are no death benefits payable for deaths before January 1, 2023.

5) Participants who have been reimbursed their full Allocated Amount will cease to be a Participant in the Plan as of the end of the month in which their Allocated Amount was reimbursed in full. No further benefits (including death benefits) will be payable from the Plan.

Section 2: Break in Service Rules & Excused Absences

Before June 30, 2025, a Participant's years of Contributory Service with the District (for purposes of applying the eligibility rules) were considered continuous under the Plan, if there was no break in employment with the District, except under the following conditions:

1) **District-Approved Leaves of Absence**: The Participant was granted District-approved leave of absence. There was no requirement to have paid contributions to the Plan during the period of any unpaid or sabbatical District-approved leave.

2) **District Layoff and Re-hire**: Participants who were laid off by the District, and who were eligible to be re-hired by the District, were considered to be on a District-approved leave of absence throughout the period of re-hire eligibility. There was no requirement to have paid contributions to the Plan during the re-hire eligibility period.

3) **Bargaining Unit Member on Part-Time Leave of Absence**: The member was granted a District-approved leave as a Tandem Teacher or was granted another MTA-represented part-time position within the District (with part-time service defined as no less than fifty percent (50%) of full-time).

4) **Employment in District Administration**: A bargaining unit employee who left the bargaining unit to take a position in District administration remained eligible to receive benefits upon Retirement if, during the entire period of service within District administration up until April 30, 2025, the Participant: (a) continuously paid administrative fees to MTA at a level established by the MTA (the requirement to pay administrative fees is not in effect after April 30, 2025); and (b) continuously paid contributions to the Plan through the date of Retirement from the District or through April 30, 2025, whichever occurred first.

5) **Agency Fee Payers (prior to December 1, 2018)**: Bargaining unit members who were formally designated as agency fee payers and who opted to become full members of the MTA as of December 1, 2018, were only required to make contributions to the Plan from that date forward until April 30, 2025. Service with the District prior to becoming a full member of MTA will not receive Contributory Service for the period of time they were classified as agency fee payers.

6) **Former Los Angeles County Employees**: Prior to April 30, 2025, a Participant could have received Contributory Service credit for periods of prior employment with the County of Los Angeles, but only when such former service was impacted by Section 44903.7 of the California Education Code, and only upon making a written request to the Plan to have prior service with the County applied toward eligibility under this Plan within the first six months of initial employment with the District. The decision to award credit for such prior service was subject to the sole discretion of the Board of Trustees.

For each of the above exceptions, Contributory Service was granted only after the Participant paid contributions owed to the Plan (if applicable) during the period of any break in service described above, and provided such payment was paid within the first six months upon returning to a full-time position represented by the MTA.

Section 3: Circumstances That May Result In Disqualification, Ineligibility, or Denial, Loss, Forfeiture, Suspension, Offset, Reduction, or Recovery of Benefits

Certain circumstances can cause you to lose eligibility for benefits under the Plan, or your benefits under the Plan could be reduced or suspended. This section describes various circumstances that can cause you to have a loss or reduction of your benefits:

If you fail to satisfy the eligibility requirements for benefits, as described in Article 2, you will not be eligible for benefits under the Plan.

If you permanently left District employment prior to retirement or prior to April 30, 2025, or discontinued MTA membership prior to April 30, 2025 (while employed by the District or in retirement), or did not pay all contributions owed to the Plan through age 67 (or through April 30, 2025, if earlier), your participation will have ended, and you are not eligible for benefits from the Plan. See Chapter 3, Loss of Eligibility, for more information.

If a Participant returns to employment with the District, in any capacity, the Participant will not be eligible for benefits under this Retiree Plan. Such Participant will be able to obtain the remainder of their Allocated Amount under the Active Plan, upon satisfying the conditions of that plan. Please contact the Trust Office for more information.

If you die on or after June 1, 2025, you will cease to be a Participant, and no further benefits will be available to you or your beneficiaries, except that if you died with a portion of an Allocated Amount, your Beneficiary, surviving spouse, or surviving Child(ren) may be eligible for death benefits as described in Article 4, section 5.

Recoupment or Offset of Overpaid Benefits. If the Plan overpays benefits to a Participant or beneficiary, the Trust Office, shall request repayment of the overpayment from the Participant and/or recipient. If the Participant and/or recipient fails to repay the Trust the amount of the overpayment, the Trust Office, as directed by the Trustees, shall have the right to recoup the overpaid amount from the applicable remaining Allocated Amount (if any) or to offset the overpayment amount against future benefits payable to the Participant and/or the recipient. The Participant and/or recipient is obligated to repay the Trust for overpaid benefits, as requested by the Trustees. This section will be administered as allowed by law.

Article 4: Plan Benefits

This Article describes benefits available from the Plan as of January 1, 2026.

Section 1: Allocated Amounts

As a result of cessation of contributions to the Plan, and the subsequent decision by the Board of Trustees to wind down the Plan, each Participant has been assigned an Allocated Amount, which is the dollar amount that the Participant can be reimbursed for Covered Expenses for which the Participant has submitted timely and documented claims for reimbursement. (For information about how to submit claims, see Article 5). The deadline for submitting claims is described in Article 5. See also Article 6, Claims and Appeals Procedures.

Each Participant's Allocated Amount is 44.93% of: the Participant's estimated total contributions paid into the Plan, minus the estimated total premium reimbursements (if any) that the Participant has already received from the Plan.[3] The Allocated Amount does not earn interest and is not

[3] Participants' estimated total contributions and estimated total premium reimbursements are determined and set forth in the Actuarial Report, which is Appendix A to this SPD. The estimated total contributions that a Participant has paid into the Plan is the Average Cumulative Contributions amount shown in column (A) of Chart 1 or 2, as applicable, for that Participant. For Participants who have previously received premium reimbursements from the Plan, the estimated total premium reimbursements that a Participant has received from the Plan is the Average Cumulative Premium Reimbursement amount in column (B) of Chart 2 that is applicable to that Participant.

credited with any investment earnings. Participants with an Allocated Amount of $0 will not be eligible for any further benefits from the Plan.

The Allocated Amount for each Participant is determined under column (D) of Chart 1 or 2 in Appendix A, as follows:

> **Chart 1** – Chart 1 applies to Participants who had not reached age 67 on June 30, 2025. Under this chart, a Participant's Allocated Amount is determined as the amount in column (D) for the Participant's date of first contribution to the Plan, as shown in the first column of the Chart. Example: Maria's Date of First Contribution to the Plan was 9/1/2006. Her Allocated Amount is $12,896.
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> **Chart 2** – Chart 2 applies to Retirees who were age 67 or older on June 30, 2025, and who have previously received premium reimbursements from the Plan. Under this chart, the Participant's Allocated Amount is shown in column (D) and is determined based on the Participant's date of first contribution to the Plan and number of years of premium reimbursement. Example: Ben's date of First Contribution to the Plan was 9/1/2003 and he has previously received 2.50 years of premium reimbursements. Ben's Allocated Amount is $3,123.

For Retirees whose estimated total premium reimbursements are greater than their estimated total contributions into the Plan, their Allocated Amount is $0, and no further benefits are payable from the Plan.

Additional Rules Pertaining to Allocated Amounts:

1. **Benefits under this Plan are not vested and are not guaranteed. Thus, the Board of Trustees can modify Allocated Amounts by amending the Plan.**

2. With respect to individual Participants, if new facts are discovered which would change a Participant's Allocated Amount (i.e., based on the new facts, the Participant's Allocated Amount under Chart 1 or 2, as applicable, would be different than initially communicated to the Participant), the Trustees will notify the Participant that his or her Allocated Amount has changed, the amount of the new Allocated Amount, and the reason for the change.

3. Some Participants who did not start receiving reimbursement benefits from the Plan at age 67 or who continued to make contributions to the Plan after attaining age 67 may be entitled to a change of their Allocated Amount, if the facts applicable to the Participant would entitle the Participant to a benefit adjustment (e.g., based on the corrected facts, the Participant would be entitled to a different Allocated Amount under chart 1 or 2, as applicable). If you think that you may be eligible for a benefit adjustment because you did not start receiving reimbursement benefits from the Plan when you attained age 67 and/or because you continued contributing to the Plan after age 67, please contact the Trust Office.

Section 2: Description of Benefits Payable

If you are a Participant in the Plan, whose Allocated Amount is greater than $0[4], you will be reimbursed for Covered Expenses up to the full amount of your Allocated Amount, provided that you submit timely and documented claims for reimbursement. Each claim that is reimbursed will reduce the balance of your Allocated Amount by the amount of the reimbursement. Once you have received Plan reimbursements equal to the full amount of your Allocated Amount, no further benefits will be payable, and you will cease to be a Participant in the Plan.

Plan Modification. The Trustees reserve the right to modify or terminate the Plan. Such modification could apply to current as well as future Participants and beneficiaries.

Benefits Not Vested. The benefits of the Plan are not vested and may be modified, amended, reduced or terminated at any time for some or all Participants (and beneficiaries) by the Board of Trustees in accordance with the terms of the Trust Agreement.

Please see Article 5 of this SPD for more information about how to submit a claim and the documentation that you must submit to support your claim for benefits.

Section 3: Covered Expenses That Can Be Reimbursed by the Plan

The Plan provides benefits that fully or partially reimburse Covered Expenses incurred by Participants who have an Allocated Amount that has not yet been fully disbursed by the Plan. Specifically, the Plan only reimburses Participants' and their Dependents' out-of-pocket costs for Covered Expenses. It does not reimburse Covered Expenses that have been paid, or will be paid, by another party or for which another party (such as a health plan or insurance company) is liable. The following medical expenses are Covered Expenses that can be reimbursed by the Plan:[5]

1) Tax deductible premiums or contribution payments paid by a Participant for health, dental, or vision insurance plans covering the Participant and/or one or more Dependents. Medicare Part B premiums are also reimbursable**. Note that, this Plan does not reimburse insurance premiums that you (or your spouse) paid with pre-tax income (such as from a spouse's HRA).**

   - **This Plan does not reimburse individual health coverage purchased through an Exchange (also known as the "marketplace," such as through Covered California) as set out in the Patient and Protection Affordable Care Act (PPACA).**

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[4] Retirees whose estimated total premium reimbursements are greater than their estimated total contributions into the Plan have an Allocated Amount of $0, and no further benefits are payable from the Plan.

[5] Your Allocated Amount may not cover the entire Covered Expense amount. If Plan benefits do not cover the entire amount of your Covered Expense, you are responsible for the balance of any Covered Expense you owe in excess of your Allocated Amount.

- **However, the Plan will reimburse premiums for excepted benefits such as standalone dental or vision coverage purchased through the Exchange.**

2) Medical expenses and supplies paid by a Participant for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including prescribed drugs and insulin (but not including any other non-prescribed drugs), which are excludable from gross income under Internal Revenue Code Section 213(d), and which have not been claimed as a deduction on the personal tax return of the Participant or any of the Participant's Dependents. Please refer to IRS Publication 502 (available online) for a description of tax-deductible medical expenses.

   - Medical expenses that fall within this category include deductibles and copays you pay on your insurance for services otherwise described above. Here are some additional examples: orthodontia, non-cosmetic dental treatment, eyeglasses or contacts needed for medical reasons (generally requiring a prescription), and hearing aids.

   - An expense or supply which is merely beneficial to the general health of an individual, such as a vacation or a gym membership to improve one's general health, does not qualify as a covered medical expense.

3) The tax-deductible portion of premium payments for qualified long-term care (LTC) insurance paid by a Participant for coverage of the Participant and/or his or her legal spouse while eligible for benefits under this Plan. LTC insurance is qualified if it: insures only LTC; is guaranteed renewable; does not provide a cash surrender value; does not provide reimbursement for Medicare expenses; and does not distribute premium refunds or similar payments to the policyholder (except generally upon the death of the insured). See IRS Publication 502 for a full description of qualified long-term care insurance and the deductible portion of the premiums for such insurance.

A Note About Cost Sharing. Please note that the Plan reimburses toward the cost of Covered Expenses, but your Allocated Amount may not cover the entire Covered Expense amount. If Plan benefits do not cover the entire amount of your Covered Expense(s), you are responsible for the balance of any Covered Expense you owe in excess of your Allocated Amount.

Section 4. Whose Covered Expenses Can Be Submitted for Reimbursement

As a retired Participant with an Allocated Amount, you can submit claims for your own Covered Expenses, as well as for Covered Expenses of your Dependents (i.e., your legal spouse and Child(ren)). However, your total benefits available to be reimbursed is your Allocated Amount, and once your Allocated Amount has been disbursed in full, no further benefits will be available to you.

Due to the costs of compliance with federal tax regulations and the potential taxation of such benefits, the Plan does not reimburse expenses incurred by domestic partners.

Section 5. Death Benefits

Deaths On or After June 1, 2025:

For deaths occurring on or after June 1, 2025, no death benefits are payable, unless the Participant died with an Allocated Amount (or a portion of the Allocated Amount) the entirety of which had not yet been disbursed in Plan benefits. In such cases, death benefits can be paid on behalf of the deceased Participant as set forth below.

If the Participant dies before his or her Allocated Amount has been disbursed in full, a death benefit equal to the remainder of the Allocated Amount will be paid to the Participant's Beneficiary(ies), surviving spouse, provided the claim is filed by the later of six months from the date of death or by May 31, 2026, as follows:

1) If the Participant is unmarried on the date of death, the remainder of the Allocated Amount shall be paid to the Beneficiary(ies).

2) If the Participant is married on the date of death and has designated his/her spouse as the Beneficiary, the remainder of the Allocated Amount shall be paid to the surviving spouse.

3) If the Participant is married and has designated a Beneficiary other than his/her spouse, one half of the remainder of the Allocated Amount shall be paid to the Participant's Beneficiary(ies) and one half shall be paid to the surviving spouse, unless the surviving spouse has waived the benefit, in which case, the entire remainder of the Allocated Amount shall be paid to the Beneficiary(ies).

4) If there is no Beneficiary(ies), the remainder of the Allocated Amount shall be paid in accordance with the intestate succession rules set forth at sections 6402(a)-(c) of the California Probate Code. This generally means the benefit will be paid to a surviving spouse. If there is no surviving spouse, then to any surviving child(ren) in equal shares or, if there are no child(ren), then to the Participant's surviving parents in equal shares or, if none, then to the Participant's surviving siblings in equal shares. The proper recipient(s) of the benefit will be determined at the sole discretion of the Board of Trustees, or in the absence of an identifiable beneficiary, it shall revert back to the Plan and shall be used to offset administrative expenses of the Plan.

Deaths Between January 1, 2023 and May 31, 2025
(Claims must be submitted by May 31, 2026)

For a Covered Retiree who died between January 1, 2023 and May 31, 2025, and for whom a death benefit has not previously been paid by the Plan, a death benefit can be paid to the Beneficiary(ies) of such deceased Covered Retiree, provided that a claim is received by the Trust Office by May 31, 2026, in the following two circumstances:

1. If such a Participant who satisfied the rules for eligibility as a Covered Retiree died before receiving benefits, a death benefit equal to contributions made by the Participant will be paid to the Participant's Beneficiary(ies) or surviving spouse, as applicable. If there is no Beneficiary or surviving spouse, the benefit will be paid in accordance with the intestate succession rules set forth at Section 6402(a)-(c) of the California Probate Code. This generally means the benefit will be paid to any surviving child(ren) in equal shares or, if there are no child(ren), then to the Participant's surviving parents in equal shares or, if none, then to the Participant's surviving siblings in equal shares. The proper recipient(s) of the benefit will be determined at the sole discretion of the Board of Trustees, or in the absence of an identifiable beneficiary, it shall revert back to the Plan and shall be used to offset administrative expenses of the Plan.

2. If such Covered Retiree began receiving benefits and died after receiving benefits for less than 48 months, the Beneficiary will receive a lump sum benefit of $6,000.00, which is twelve times the then-allowable monthly reimbursement rate of $500.00. If such Retiree received benefits for 48 months or more, no death benefits are payable.

There are no death benefits payable for deaths that occurred before January 1, 2023.

Section 6. Retiree Health Benefits and Options Available from MUSD

Retirees from the Montebello Unified School District ("MUSD" or "District") may choose any CalPERS health plan they like so long as it is a plan available to them (e.g., Basic plans for under 65, and Medicare plans for those over 65). Once you have selected a CalPERS plan, the premium for medical coverage is deducted monthly from your pension benefit payment.

MUSD retirees who have completed at least 15 years of service with the District and are at least 55 years old at the time of retirement are eligible for monthly District reimbursements towards the cost of their health care premiums for CalPERS health plans until they reach age 67.

Beginning at age 67, retirees have the option to continue enrollment in their CalPERS health plan. At this point, the MUSD has no further involvement, and the retiree will be responsible for the full premium on their CalPERS health plan going forward. Additionally, a retiree age 67 or older has the option to look outside of CalPERS for health coverage.

For information about the health plans and options available from CalPERS, please contact CalPERS as listed in Article 6, section 6.5.

Article 5: How to Submit Claims for Reimbursement

Before any claims can be reimbursed by the Plan, you must complete the Plan's new enrollment form. None of your claims can be reimbursed, unless you have submitted a new completed enrollment form to the Trust Office. **Note**: This paragraph does not apply to claims processed in accordance with the box on page 3.

Section 1. Deadline to Submit Claims for Reimbursement

In order to present a claim for benefits, the Participant must submit a claim with all required documentation supporting the claim, by the **annual claims deadline**, **which is three (3) months after the end of the calendar year in which you paid the Covered Expense (i.e., no later than March 31st,** for expenses you paid during the prior calendar year).

Claims submitted after this March 31st deadline (i.e., more than 3 months after the end of the calendar year in which you paid the Covered Expense), **will not be eligible for reimbursement**.

There is one exception to the claims deadline described above. By March 31, 2026, you may submit fully documented claims for reimbursement of Covered Expenses that you paid during the 2024 or 2025 calendar year (i.e., from January 1, 2024-December 31, 2025) while you were a Covered Retiree.

The claims submission deadline for death benefits varies. Please see Article 4, section 5 (Death Benefits) and the Claims and Appeals Procedures in Article 6 of this SPD.

Section 2. For Reimbursement of CalPERS Health Plan Premiums

1) If you are a Retiree age 67 or older and continue your enrollment in a CalPERS health plan, your monthly premium for medical coverage is deducted from your monthly pension benefit payment. This Plan will reimburse you for up to the full monthly premium through a deposit made to your designated account at any eligible financial institution, until your Allocated Amount has been disbursed in full.

2) The amount of your CalPERS premium that is eligible for reimbursement from the Plan (if your Allocated Amount is sufficient) is the amount that you are required to pay minus an ACH fee (currently $ .35 per ACH transaction). If the District reimburses you for any portion of your premium, the Plan will not reimburse you for that portion.

3) You can elect to have this medical premium reimbursed via deposit to your designated account by properly completing the enrollment form provided by the Trust Office. If you mark this election on the enrollment form, you do not need to upload a claim to your account on the Wex platform to have your CalPERS premium(s) reimbursed. Once your Allocated Amount has been exhausted, no further benefits will be payable, and the Plan will have no further involvement. You will then be responsible for the full premium on your CalPERS health plan going forward (your monthly premium for the CalPERS plan will continue to be deducted monthly from your pension benefit payment).

Section 3. For Reimbursement of All Other Covered Expenses

There are three ways you can submit claims for reimbursement: (1) by paying the claim with a Debit Card issued to you by the Trust Office; (2) by submitting an electronic claim using the Wex Platform; or (3) by submitting a paper claim to the Trust Office.

If your electronic or written claim for premium reimbursement is determined to be eligible for reimbursement, it will be reimbursed as a deposit made to your designated account at any eligible financial institution, until your Allocated Amount is exhausted and has been reimbursed in full. Once your Allocated Amount has been reimbursed in full, no further benefits will be payable from the Plan, and your participation in the Plan will terminate.

Claims Using Your Debit Card

The Trust Office will issue Plan debit card(s) to Participants after the enrollment form has been completed and processed.

Your Plan debit card can be used to pay for certain Covered Expenses at the point of sale (e.g., at your Doctor's office or at a pharmacy counter). The payment of an expense with your debit card is considered the submission of a claim for benefits.

While Plan debit cards are generally programmed to approve (pay) Covered Expenses that can be auto-substantiated at the point of purchase, they may also pay some ineligible expenses because verification systems are unable to confirm that such expenses comply with IRS rules (this could happen, for example, where a vendor sells both eligible and ineligible items).

If your debit card allows a transaction (i.e., pays an expense) for which there is inadequate substantiation (i.e., if the debit card allows a transaction that does not satisfy IRS-compliant substantiation requirements), the Trust Office will send you a letter requesting documentation that substantiates the claim. It may also send you a response in the Wex platform and/or an email. You will have up to 45 days to respond. In addition, the Trust Office will suspend your debit card (so that you cannot use it) until you either: (1) provide the necessary documentation substantiating the expense; or (2) repay the Trust the full amount of the questioned transaction.

If you do not provide the Trust Office with the substantiation documentation or repay the Trust by the deadline, the Trust Office will issue you an IRS Form 1099, after the end of the applicable taxable year, reflecting the receipt of a taxable distribution (meaning that the expense reimbursement will be income to you). You will be responsible for any federal, state, or local income taxes or penalties due on these amounts. **Thus, it is in your interest to quickly respond to any Trust Office request relating to your use of the Plan debit card.**

After the 45-day period, your account will be unsuspended, and you will be able to continue to use the debit card and submit claims for reimbursement.

It is your responsibility to ensure the Trust Office has accurate and up-to-date contact information to ensure proper delivery of any notices or tax forms. The Trust Office will not be responsible for any delays or penalties resulting from incorrect or outdated contact information.

Expenses That Cannot Be Paid with A Debit Card

Plan debit cards are programmed to deny payment for certain transaction for which real-time eligibility verification systems are unable to confirm IRS-compliant substantiation.[6] If the debit card cannot be used to pay a Covered Expense(s), you will have to submit an electronic or paper claim (with supporting documentation) to be reimbursed for those expenses.

Your debit card cannot be used internationally. If you do seek medical care internationally, all documentation (itemized statements, Explanation of Benefits (EOBs), etc.) must be in English. Additionally, any medical service or prescription sought internationally must be legal and considered an eligible medical expense under Internal Revenue Code section 213(d) in the United States. Please note, imported prescriptions are not generally covered. You must submit an electronic or paper claim (with supporting documentation) to be reimbursed for these international medical expenses.

Here is a non-exhaustive list of some types of expenses for which the Plan debit card should not be able to be used, and for which you will need to submit paper or electronic claims:

i. Over the counter ("OTC") drugs and medicines, such as allergy medications, pain relievers, supplements, and certain dermatological products;

ii. Insurance premiums;

iii. Equipment or supplies that can be used for general health, such as treadmills, hot tubs or saunas (such items generally will not qualify as Covered Expenses but may be Covered Expenses where the item is needed to treat a specified medical condition).

iv. Coverage typically excludes purely cosmetic procedures, such as a reduction mammoplasty performed solely for cosmetic reasons. (However, breast reconstructive surgery related to a mastectomy, congenital anomaly, or accident, including all stages of reconstruction, prostheses, and addressing complications to restore symmetry may be a Covered Expense where the item is needed to treat a specific medical condition).

Electronic Claims

To present an electronic claim for benefits under the Plan, you will first need to register an account on the Wex Platform. Once you have registered an account, you can then submit claims and required documentation supporting your claims, in your account on the Wex Platform.

The Wex platform allows you to upload a photo or digital scan of your supporting documentation (e.g., receipts for medical expenses) to accompany your claim. The Trust Office will provide you "Instructions for Using Your Wex Portal," which provides instructions for registering an account

[6] If your Plan debit card approves a transaction that does not meet IRS standards for compliant substantiation, you will be responsible for providing the Trust Office with the necessary documentation to substantiate the expense.

and filing a claim on the Wex Platform. Submitting your claims on the Wex Platform will typically result in faster reimbursement than if you submit paper claims.

Paper Claims

If you are not able to use the Wex Platform to submit your claims, you may, instead, submit a paper claim to the Trust Office, on the Plan's approved claim form. The claim form must be accompanied by all supporting documentation needed for the Trust Office to approve the claim. See section 5 below for the documentation needed.

You may contact the Trust Office to request the Plan's claim form. Please mail your claims with supporting documentation to the Trust Office at:

Coast Benefits
3530 Camino del Rio North, Suite 110
San Diego, CA 92108
Phone: (800) 886-7559
Fax: (619) 501-3250

Section 4. All Claim Payments Must Reimburse Covered Expenses That You Have Paid.

All reimbursement payments from the Plan must reimburse Covered Expenses that you have already paid for. You cannot receive reimbursement based on an invoice for services or premiums that you have not yet paid, i.e., you cannot receive an advance to use for payment of a medical bill. When you request reimbursement, you must prove that you have already paid the Covered Expense, regardless of whether that payment is for medical services, copays, deductibles, or insurance premiums.

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

Section 5. Documentation Needed to Support Claims for Covered Expenses

The documentation you will need to submit to support your claim for reimbursement depends on the type of Covered Expense and also whether you used your Plan Debit Card to pay the expense. See subsections A through D below.

Claims Paid by Plan Debit Card

As discussed in section 2 above, Plan debit cards are generally programmed to approve (pay) Covered Expenses that can be auto-substantiated at the point of purchase. However, they may also pay some ineligible expenses.

If your debit card allows a transaction (i.e., pays an expense) for which there is inadequate substantiation (i.e., if the debit card allows a transaction that does not satisfy IRS-compliant substantiation requirements), the Trust Office will send you a letter requesting documentation that substantiates the claim. You will have up to 45 days to respond. In addition, the Trust Office will suspend your debit card (so that you cannot use it) until you either: (1) provide the necessary documentation substantiating the expense; or (2) repay the Trust the full amount of the questioned transaction. The documentation you will need to substantiate the expense depends on the item that was purchased and will be detailed in the Fund's letter to you.

Claims Submitted on the Wex Platform or by Mail

As detailed in subsections A.-D., below, the supporting documentation that you will need to submit depends on whether you are seeking reimbursement for:

- Covered Expenses (Other Than Premiums for Insurance or Medicare)
- Monthly Insurance Premium Payments
- Medicare Premiums Deducted from Social Security Payments
- Annual Premium Payments

The Trust Office will not issue your benefit claim reimbursement until it receives proper documentation of your prior payment of the Covered Expense.

A. For Reimbursement of Covered Expenses (Other Than Premiums for Insurance or Medicare):

For each claim to reimburse Covered Expenses (except premiums for insurance or Medicare), you must submit:

1. A completed and signed claim form; and
2. Accompanying documentation from an independent third party that confirms the following for the Covered Expense:
    a. The date that the Covered Expense was provided; and
    b. A description of the Covered Expense for which reimbursement is sought; and
    c. The person to whom the Covered Expense was provided; and
3. Proof that you paid the Covered Expense, which includes one of the following:

- Canceled check drawn to the name of the Covered Expense provider, bank statement showing check payment, or credit card statement showing payment; or
- Copy of confirmation of electronic payment to the Covered Expense provider; or
- Receipt for payment from the Covered Expense provider; or
- Other proof approved by the Board of Trustees.

In addition to the above, you may need to provide further documentation to the Trust Office to prove that the expense you incurred qualifies as a Covered Expense (e.g., a letter from your licensed healthcare provider that clearly states that the item is required for the treatment or management of a specified medical condition).

B. ***For Reimbursement of Monthly Insurance Premiums:***

For reimbursement of recurring monthly insurance premiums, you can submit claims for reimbursement monthly, or you can submit them less frequently by submitting one claim for reimbursement of several monthly premium payments (with substantiating documentation), as long as you comply with the annual claims' deadline. However, you will be reimbursed only for months for which the Trust Office has timely received your claim and supporting documentation (i.e., by the annual claims deadline). If your premium amount changes (e.g., due to Medicare eligibility), you must submit a new claim form and third-party insurance documentation of your new premiums.

For each claim for reimbursement of recurring monthly premium payments, you must provide:

1. A completed and signed claim form for the premium reimbursement, and
2. Documentation from an independent third party substantiating the insurance coverage (see below for more information), and
3. Documentation substantiating your payment of each monthly premium (see below for more information).

Documentation To Substantiate Insurance Coverage

Your completed signed claim form must be accompanied by documentation from an independent third party, which substantiates the following:

- The dates of coverage for the insurance coverage or policy; and
- A description of the insurance premiums, i.e., the type of insurance provided (e.g., dental, vision, medical insurance); and
- The monthly premium amount that you are required to pay for the insurance coverage.

You can use the same "insurance substantiation" documentation for each claim you submit within the policy year of your insurance coverage, unless there is a change to your monthly premium amount. If there is a change in premium amount (e.g., due to adding/deleting a family member to/from your policy), then you will need to complete a new claim form and provide new insurance substantiation documentation to the Trust Office.

Documentation To Substantiate Payment of Each Monthly Premium

To receive reimbursement of recurring monthly premiums (except for Medicare premiums deducted from Social Security payments), you must submit proof that you have paid the premium each month, and the payment amount must match the amount claimed on your claim form (and shown in the insurance substantiation documentation of your insurance coverage). Examples of proof of payment are:

- Canceled check drawn to the name of the insurance carrier;
- Bank or credit card statement showing payment to insurance carrier;
- Copy of confirmation of electronic payment to the insurance carrier, including pension statement showing deduction for insurance premiums; or
- Receipt for payment from the insurance carrier.

C. For Reimbursement of Medicare Premiums Deducted From Social Security Payments

Because you receive only one annual statement showing the monthly deduction for Medicare payments, you can submit that statement annually with your claim form, and the Trust Office will reimburse you monthly for that amount, until your Allocated Amount is exhausted, for the rest of the year. This rule applies to Medicare premiums, e.g., Parts B and D. You do not need to submit any other documentation unless your Medicare premium is paid via check or by ACH. If your Medicare premium changes during the year (e.g., a spouse is added to Medicare during the year or a spouse dies), then you must submit the new Social Security statement and a new claim form to the Trust Office within 90 days of receipt of such statement.

However, you must substantiate your Medicare Supplemental or Medigap premiums on a monthly basis as you would for other monthly insurance premiums.

If the Plan reimburses more than it should have, the Trust shall have the right to offset against future payment or otherwise pursue recoupment.

D. For Reimbursement of Annual Premium Payments

If you pay your insurance premium in one lump sum annually for an entire year of coverage, then you can submit a claim form, third party documentation of insurance coverage, and proof of premium payment just once per year after making your annual payment. You do not need to

resubmit this same documentation each month. The Trust Office will reimburse your annual premium payment up to your Allocated Amount.

Article 6: Claims and Appeals Procedures

The claims and appeals procedures described below apply to claims for eligibility and benefits under this Plan. A Participant may designate an authorized representative to file a claim or appeal on the Participant's behalf, but only if the Participant has designated the individual to act on the Participant's behalf with respect to the claim and/or appeal at issue. Such designation must be in writing on a form acceptable to the Board of Trustees. Only an individual, not an entity, can act as a Participant's authorized representative.

6.1. Acceptance or Denial of Claims by the Trust Office.

(a) **Standard Claim Decision - Timing**. The Trust Office shall consider each written or electronic claim for Plan reimbursement and determine whether to grant or deny coverage under the Plan. Subject to sections 6.1(b) and 6.1(c) below, the Trust Office shall send written notification of its decision to the Participant not later than thirty (30) days after receipt of the Participant's claim. If coverage is granted, the Participant shall receive payment. If the claim is denied, the Participant has the right to appeal the claim, pursuant to section 6.2 hereof.

The denial notification shall include the following information:

(i) The specific reason(s) for such denial;

(ii) Specific reference to the Plan provisions upon which the denial is based;

(iii) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Participant's claim for reimbursement; and

(iv) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits and a statement of the Participant's right to bring an action under ERISA Section 502(a), after exhausting the Plan's appeal procedures herein.

(b) **Extension of Time - Special Circumstances**. If the Trust Office determines that special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the Participant prior to the termination of the initial thirty (30) day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trust Office expects to render a claim determination. In no event shall such extension exceed a period of fifteen (15) days from the end of the initial period (45 days total).

(c) **Extension of Time — Failure to Submit Information**. The period of time for the Trust Office to make a claim determination may be extended if the Participant fails to submit all information necessary for the Trust Office to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Participant until the date the Participant provides to the Trust Office the requested information. The Participant shall be allowed at least forty-five (45) days from receipt of the request for additional information within which to provide the information. If you do not provide the information by the deadline, your claim will be decided on the information in your claim file.

(d) **Deadline for Submission of Death Benefit Claims**. For claims for death benefits, the claims must be filed with the Trust Office pursuant to the following time frames:

(i) For deaths between January 1, 2023 through May 31, 2025, the claims must be filed by May 31, 2026.

(ii) For deaths on or after June 1, 2025, the claims must be filed by the later of six months after the date of death or by May 31, 2026.

Note: There are no death benefits payable for deaths that occurred before January 1, 2023.

6.2. Appeal Procedures. Participants and any person who claims to be entitled to reimbursement under this Plan must follow the claims and appeals procedures in Article 6 herein.

(a) **Sole Procedures**. The procedures specified in this Section shall be the sole and exclusive procedures available to a person dissatisfied with an eligibility determination or claim denial (including partial denials), or who is otherwise adversely affected by any action of the Trustees.

(b) **Request for Hearing**. Any person whose claim has been denied may appeal to the Trustees in writing within one hundred eighty-one (181) calendar days after receipt of notification of the denial of the claim or other adverse determination. The appeal letter should indicate the reasons why the Participant believes that the grounds for denial of reimbursement are inapplicable. The Participant may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for reimbursement to the Trustees. The Participant shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for reimbursement.

(c) **Decision on Appeal.** No later than sixty (60) days after receipt by the Plan of the claimant's request for review of an adverse benefit determination, the Trustees shall issue a written decision, affirming, modifying or setting aside the former decision. Any notification of a denial shall include the following information:

(i) The specific reason(s) for such denial;

(ii) Specific reference to the Plan provisions upon which the denial is based;

(iii) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Participant's claim for reimbursement; and

(iv) An explanation of the Participant's right to bring an action in federal court under ERISA Section 502(a), after exhausting the Plan's appeal procedures.

The appeal must be submitted to:

Plan Administrator
Board of Trustees
Montebello Teachers Association Retiree Supplemental Health Plan
c/o Coast Benefits
3530 Camino Del Rio North, Suite 110
San Deigo, CA 92108

6.3. Board of Trustees' Discretionary Authority

The Board of Trustees of this Plan hold the exclusive, discretionary authority and power to make factual findings, to fix omissions, to resolve Plan ambiguities, to construe the terms of the Plan, to make benefit and eligibility determinations, and to resolve any other dispute under this Plan. The Board of Trustees will either approve your appeal, request additional information and additional time to consider your appeal, or deny your appeal. The decision of the Board of Trustees is final and binding upon you and the Board of Trustees.

6.4. Time Limit and Other Limitations on Filing a Lawsuit

If you decide to file a legal action against the Plan, a Trustee, the Board, or other Plan fiduciary, you must first exhaust the claims and appeals procedures above, and you must file such action within 180 days from the date you receive the final decision, denying your appeal.

By participating in the Plan, all Participants, Employees, Pensioners, Beneficiaries, and eligible individuals waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action brought in any forum (including but not limited to court, arbitration, or the like), where such action is alleged to arise out of or relating to any dispute, claim or controversy relating to the Plan. All Participants, Employees, Pensioners, Beneficiaries and eligible individuals agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

6.5. CalPERS Health Plans

For claims and appeals procedures under health plans administered through CalPERS, you should carefully review that CalPERS plan's claims and appeals procedures for services which are denied in whole or in part by any of the listed providers. If you wish to file a claim, dispute, complaint,

or appeal a claim, you must follow that CalPERS plan's procedures for claims and appeals outlined in its plan documents. For questions about benefits provided through CalPERS, please contact:

CalPERS Benefits Services Division
P.O. Box 942716
Sacramento, CA 94229-2716
(888) 225-7377

Article 7: Miscellaneous

7.1. Benefits Not Vested. The benefits of this Plan are not vested and may be modified, amended, reduced or terminated at any time for any reason for some or all Participants (and beneficiaries) by the Board of Trustees, *in its sole and absolute discretion,* in accordance with the terms of the Trust Agreement.

a. **Plan Modification.** The Trustees reserve the right to modify or terminate the Plan. Such modification could apply to current as well as future Participants and beneficiaries.

7.2. Recoupment or Offset of Overpaid Benefits. If the Plan overpays benefits to a Participant, beneficiary or any other person, the Trust Office, shall request repayment of the overpayment from the Participant and/or recipient. If the Participant and/or recipient fails to repay the Trust the amount of the overpayment, the Trust Office, as directed by the Trustees, shall have the right to recoup the overpaid amount from the applicable remaining Allocated Amount (if any) or to offset the overpayment amount against future benefits payable to the Participant and/or the recipient. The Participant and/or recipient is obligated to repay the Trust for overpaid benefits, as requested by the Trustees. This section will be administered as allowed by law.

7.3. Trustee Authority. The Trustees have the authority and broad discretion to determine eligibility for benefits, to interpret and apply the provisions of the Trust Agreement and this SPD, or of the benefit plans, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision shall be binding and conclusive.

7.4. No Rebate or Refund. Participants shall receive benefits from the Plan only as reimbursement of Covered Expenses. No Participant shall be eligible for rebates or refunds of any contributions made, except as reimbursement of Covered Expenses.

7.5. No Assignment or Encumbrance of Benefits. Except as required by law, no benefit payment under this Plan shall be subject in any way to assignment, alienation, sale, transfer, pledge, attachment, garnishment, or encumbrance of any kind. Any attempt by a Participant, or any other person or entity, to assign, alienate, sell, transfer, pledge, attach, garnish or encumber the benefits or monies due from this Plan, shall be void. The Plan will not honor any direct or indirect arrangement, whether revocable or irrevocable, whereby a person or entity acquires or receives

from a Participant or Beneficiary any right or interest under this Plan. Any such arrangements are void under the Plan.

7.6. Protection of Benefits From Creditors. The Plan and Trust Fund are exempt from all claims from creditors or other claimants and from all orders, decrees, garnishments, executions, and legal processes or proceedings.

7.7. Limitation of Rights. Neither the establishment of the Plan and the Trust, nor any modifications thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving any Participant or other person any legal or equitable right of action, or any recourse against the MTA or its employees, the Trust, the Trust Office or its employees, or the Trustees, except as provided in this Plan and the Trust Agreement.

7.8. Amendment and Termination. All benefits are paid from Trust Fund assets, and the Plan's obligation to make any benefit payment shall be limited by amounts held in the Trust Fund and the financial ability of the Plan at the time of the payment.

In accordance with the terms of the Trust Agreement, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time to:

(a) modify or reduce benefits, including the Allocated Amount;
(b) amend or rescind any provision of this Plan; or
(c) terminate the Plan.

Any such changes may apply to some, or all current and/or future Participants and their beneficiaries as determined by the Trustees. Amendments, including Plan termination, will be made by action of the Board of Trustees pursuant to the Trust Agreement.

Upon termination of the Plan, any remaining assets held by the Trust Fund shall be applied towards the payment of benefits and for any remaining obligations of the Trust. Any remaining assets of the Trust not otherwise paid towards benefits and administrative expenses, shall be allocated and distributed in accordance with Section 501(c)(9) of the Internal Revenue Code and regulations thereunder.

7.9. No Reimbursements to Divorced or Legally Separated Spouses; or to Domestic Partners of Terminated Domestic Partnerships.

This Plan does not reimburse benefits to: divorced or legally separated spouses; or to domestic partners of terminated domestic partnerships. No Trust monies can be used in whole or part to satisfy a community property claim. It is the Covered Retiree's responsibility to satisfy any and all community property claims with assets other than those involving Trust benefits.

7.10. Summary of Plan's Privacy Practices

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the health plans protect the confidentiality of your private health information. The Plan

will protect the privacy of your protected health information (PHI). The Plan will also require contracting providers and business associates such as the Plan's lawyers, accountants, and third-party professionals, to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask the Administrative Office for an accounting of certain disclosures of your PHI.

The Plan may use or disclose your PHI for treatment, payment and health care operations purposes, including health research and measuring the quality of care and medical services. The Plan is sometimes required by law to give PHI to government agencies or in judicial action. In addition, your identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. The Plan will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as provided in the Plan's Notice of Privacy Practices. Giving the Plan authorization is at your discretion.

This is only a brief summary of some of the Plan's key privacy practices. The Plan's Notice of Privacy Practices describing the Plan's policies and procedures for preserving the confidentiality of your medical records and other PHI is available at no cost and will be furnished to you upon your request. To request a copy, please contact:

Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Phone: (800) 886-7559
Fax: (619) 501-3250

Article 8: ERISA Rights

As a Participant in the Montebello Teachers Association Retiree Supplemental Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the plan administrator office and at other specified locations, such as worksites and union halls, all documents governing the plan. These documents include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts (if any), collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated

Summary Plan Description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court but only after exhausting the Plan's claims and appeals procedures herein.

However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Trust Office (Coast Benefits). If you have any further questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by accessing the resources of the EBSA online at **https://www.dol.gov/agencies/ebsa** or contact the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at **www.dol.gov/ebsa**.

Women's Health and Cancer Rights Act of 1998

This Plan does not provide medical benefits to you directly. However, pursuant to the Women's Health and Cancer Right Act of 1998, the medical plan you select from CalPERS should provide coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and physical complications at all state of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the plan at (800) 886-7559 for more information.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Article 9: General Plan Information

Plan Name. Montebello Teachers Association Retiree Supplemental Health Plan for Retired Employees.

Plan Type. This is a welfare plan that reimburses medical premium costs for retiree health benefits and other qualifying medical expenses. The Plan is a Voluntary Employee Beneficiary Association (VEBA) that is tax exempt under IRC section 501(c)(9).

Plan Number. Employer Identification Number issued to the Plan is 95-414329. The Plan Number is 501.

Funding Medium. Trust Fund assets are held in trust at US Bank and are managed by Verus, the Plan's financial advisor.

Contribution Source. The reimbursements described in this booklet are provided through member contributions made during active employment and retirement through April 30, 2025; and through investment earnings under this Plan.

The fiscal records of the Plan are kept separately for each fiscal plan year. The fiscal year begins on September 1 and ends on August 31.

Plan Administrator
Board of Trustees
Montebello Teachers Association Retiree Supplemental Health Plan
c/o Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Phone: (800) 886-7559
Fax: (619) 501-3250

The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). The Board has contracted with a third-party administrator, Coast Benefits, to handle the day-to-day business of the Plan.

Agent for Service of Legal Process:

Coast Benefits
Attn: Plan Administrator
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108

Legal process may also be served on a Plan Trustee.

Plan Administration

The Plan is administered by the Board of Trustees, which acts on the behalf of Participants and the beneficiaries. If you wish to contact the Board of Trustees, you may do so at the address and phone number shown below.

The routine functions of the Plan are performed by Coast Benefits, a third-party administrator (TPA) which functions by contract as the Trust Office for the Plan:

Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Phone: (800) 886-7559
Fax: (619) 501-3250

The names of the members of the Board of Trustees, as of July 1, 2025, are:

- Victoria Landeros-Lopez, President MTA
- Julian De La Torre, Trustee (Retiree)
- Andy Shinn, Trustee
- Elizabeth Gasca, Trustee
- Rafael Gutierrez, Trustee

Ex-officio non-voting Trustees are David Navar and Doug Patzkowski.

Board members may be contacted through the Trust Office, Coast Benefits.

Rael & Letson

160 Bovet Road, Suite 203
San Mateo, CA 94402

(650) 341-3311
rael-letson.com

Memorandum

To: Participants of the Montebello Teachers Association Retiree Supplemental Health Plan

From: Wang Li, Associate of the Society of Actuaries

Date: September 24, 2025

Re: MTA Trust Asset Allocation

After careful deliberations and a review of the Plan's current financial status, the Board of Trustees has adopted the following methodology to allocate the Plan assets available for benefits, which the Board has determined to be approximately **$16,000,000**. The result is that for participants who will receive Plan benefits in the future, such participants' share of available Plan assets will be **44.93%** of their estimated contributions net of premium reimbursements (referred to as "Total Net Contributions"). In other words, each such participant's Allocated Amount will be **44.93%** of the participant's total estimated contributions paid into the Plan, minus the total estimated premium reimbursements (if any) the participant has received. The Allocated Amount is the amount that the participant will be able to receive from the Plan in benefits by submitting claims for reimbursement of covered health care expenses.

In performing this calculation, the Plan's current participants are divided into two groups[1]. (All retirees' ages are determined as of June 30, 2025, when benefits were suspended):

1. Current actives and retirees under age 67 who have not commenced benefits. Based on each person's date of first contribution, we estimate each person's total contribution into the Trust through April 2025.

2. Current retirees age 67 or older and who have commenced receipt of Plan premium reimbursements. Based on each retiree's date of first contribution, we estimate the retiree's Total Net Contributions into the Plan. The retiree's Total Net Contributions are: the retiree's estimated total contributions made to the Plan prior to age 67 minus the retiree's estimated total premium reimbursements he/she received from the Plan from age 67 through June 2025.

By two-year bands, based on the first contribution date, each participant's Allocated Amount is based on their estimated net contributions into the Plan (i.e., contributions after any premium reimbursements are subtracted out) multiplied by a factor of **44.93%**. For retirees in group 2 with estimated total premium reimbursements greater than their estimated total contributions, their allocation is **$0, and no further benefits are available from the Plan.**

Each participant's total contributions and premium reimbursements are calculated using amounts in Exhibits A and B.

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[1] If you do not fit into one of these groups (e.g., you are over 67 and have not yet commenced receiving benefits, you delayed receiving benefits until 68 or older or you contributed to the Plan after age 67), please contact the Trust Office.

Chart 1: Current Actives and Retirees Less Than Age 67

Participant's Date of First Contribution	Participant Count	(A) Average Cumulative Contributions[1]	(B) Average Cumulative Premium Reimbursement	(C) = (A) - (B) Cumulative Contributions Net of Reimbursement	(D) 44.93% x (C) = Allocated Amount
Pre 9/1/1988	42	$39,583	$0	$39,583	$17,785
9/1/1988 - 8/31/1990	20	38,813	0	38,813	17,438
9/1/1990 - 8/31/1992	8	38,069	0	38,069	17,104
9/1/1992 - 8/31/1994	22	36,900	0	36,900	16,579
9/1/1994 - 8/31/1996	51	35,898	0	35,898	16,129
9/1/1996 - 8/31/1998	142	34,844	0	34,844	15,656
9/1/1998 - 8/31/2000	150	33,670	0	33,670	15,128
9/1/2000 - 8/31/2002	126	32,643	0	32,643	14,666
9/1/2002 - 8/31/2004	102	31,406	0	31,406	14,111
9/1/2004 - 8/31/2006	64	30,017	0	30,017	13,487
9/1/2006 - 8/31/2008	80	28,703	0	28,703	12,896
9/1/2008 - 8/31/2010	45	26,817	0	26,817	12,049
9/1/2010 - 8/31/2012	22	24,605	0	24,605	11,055
9/1/2012 - 8/31/2014	43	22,394	0	22,394	10,062
9/1/2014 - 8/31/2016	55	20,105	0	20,105	9,033
9/1/2016 - 8/31/2018	47	16,820	0	16,820	7,557
9/1/2018 - 8/31/2020	21	13,886	0	13,886	6,239
9/1/2020 - 8/31/2022	5	**10,370**	0	10,370	4,659
9/1/2022 - 8/31/2024	116	4,900	0	4,900	2,202
Post 8/31/2024	1	2,400	0	2,400	1,078
Grand Total	**1,162**	**$27,917**	**$0**	**$27,917**	**$12,543**
Current Actives and Retirees Less Than Age 67 Subtotal					**14,575,090**

[1] The Average Cumulative Contributions in each row is the average of the Cumulative Contribution amounts, from Exhibit A, Column (B), for all participants whose Date of First Contribution is included in that row. Participants are assigned their average Cumulative Contribution amount regardless of the specific date that their First Contribution was actually made within the two-year band in the first column of this Chart 1.

Example: In the row for Date of First Contribution from 9/1/2020-8/31/2022, the **$10,370** Average Cumulative Contributions amount is determined by taking the average of the Cumulative Contribution amounts from Exhibit A, Column (B), for each of the 5 participants whose Date of First Contribution was from 9/1/2020-8/31/2022. The following Table sets out the details of this example:

Participant	Date of First Contribution	Cumulative Contribution (from Exhibit A, Column (B))
1	05/01/2022	8,850
2	09/01/2020	10,750
3	04/01/2021	10,750
4	11/01/2020	10,750
5	08/01/2021	10,750
	Average	**10,370**

Chart 2: Current Retirees Age 67 or Older and Who Have Received Premium Reimbursement

Retiree's Date of First Contribution	# of Years of Premium Reimbursement Since Age 67	Retiree Count	(A) Average Cumulative Contributions To Age 67[1]	(B) Average Cumulative Premium Reimbursement[2]	(C) = (A) - (B) Cumulative Contributions Net of Reimbursement	(D) 44.93% x (C) = Allocated Amount
Pre 9/1/1988	0.00 - 0.99	21	$36,962	$5,221	$31,740	$14,261
	1.00 - 1.99	28	34,377	9,836	24,541	11,026
	2.00 - 2.99	25	32,218	15,606	16,612	7,464
	3.00 - 3.99	37	30,423	20,469	9,954	4,472
	4.00 - 4.99	37	28,381	25,293	3,088	1,387
	5.00 - 5.99	38	26,621	30,332	-3,711	0
	6.00+	452	16,241	67,913	-51,672	0
9/1/1988 - 8/31/1990	0.00 - 0.99	1	36,500	7,650	28,850	12,962
	1.00 - 1.99	1	34,000	7,650	26,350	11,839
	2.00 - 2.99	6	31,058	15,300	15,758	7,080
	3.00 - 3.99	5	29,460	20,910	8,550	3,842
	4.00 - 4.99	2	27,800	22,950	4,850	2,179
	5.00 - 5.99	3	25,950	29,750	-3,800	0
	6.00+	24	16,892	61,244	-44,352	0
9/1/1990 - 8/31/1992	1.00 - 1.99	2	33,300	7,650	25,650	11,525
	2.00 - 2.99	1	30,950	12,750	18,200	8,177
	3.00 - 3.99	1	29,000	22,950	6,050	2,718
	4.00 - 4.99	2	26,175	25,500	675	303
	5.00 - 5.99	2	25,250	33,150	-7,900	0
	6.00+	2	18,700	49,021	-30,321	0
9/1/1992 - 8/31/1994	0.00 - 0.99	1	34,350	7,650	26,700	11,996
	1.00 - 1.99	2	32,125	10,200	21,925	9,851
	2.00 - 2.99	2	30,400	12,750	17,650	7,930
	3.00 - 3.99	2	28,175	20,400	7,775	3,493
	5.00 - 5.99	3	24,100	29,750	-5,650	0
	6.00+	8	15,719	62,046	-46,327	0
9/1/1994 - 8/31/1996	0.00 - 0.99	2	32,000	7,650	24,350	10,940
	1.00 - 1.99	1	30,750	12,750	18,000	8,087
	2.00 - 2.99	2	28,750	15,300	13,450	6,043
	3.00 - 3.99	4	27,213	19,125	8,088	3,634
	4.00 - 4.99	1	23,050	28,050	-5,000	0
	6.00+	6	15,175	60,492	-45,317	0
9/1/1996 - 8/31/1998	0.00 - 0.99	3	32,700	5,950	26,750	12,019
	1.00 - 1.99	1	30,200	12,750	17,450	7,840
	2.00 - 2.99	1	25,700	17,850	7,850	3,527
	3.00 - 3.99	2	24,075	22,950	1,125	505
	4.00 - 4.99	2	24,075	28,050	-3,975	0
	5.00 - 5.99	2	21,325	30,600	-9,275	0
	6.00+	6	14,892	56,297	-41,405	0
9/1/1998 - 8/31/2000	0.00 - 0.99	3	30,767	7,650	23,117	10,386
	1.00 - 1.99	1	26,550	12,750	13,800	6,200
	3.00 - 3.99	2	24,600	20,400	4,200	1,887
	4.00 - 4.99	1	23,250	22,950	300	135
	5.00 - 5.99	1	21,400	33,150	-11,750	0
	6.00+	11	15,564	48,372	-32,808	0

Chart 2: Current Retirees Age 67 or Older and Who Have Received Premium Reimbursement (Continued)

Retiree's Date of First Contribution	# of Years of Premium Reimbursement Since Age 67	Retiree Count	(A) Average Cumulative Contributions To Age 67[1]	(B) Average Cumulative Premium Reimbursement[2]	(C) = (A) - (B) Cumulative Contributions Net of Reimbursement	(D) 44.93% x (C) = Allocated Amount
	0.00 - 0.99	1	29,900	2,550	27,350	12,288
	1.00 - 1.99	2	**26,400**	**10,200**	16,200	7,279
	2.00 - 2.99	2	24,050	17,850	6,200	2,786
9/1/2000 - 8/31/2002	3.00 - 3.99	3	23,650	22,950	700	315
	4.00 - 4.99	3	21,133	26,350	-5,217	0
	5.00 - 5.99	1	19,700	28,050	-8,350	0
	6.00+	11	10,623	62,310	-51,688	0
	0.00 - 0.99	1	29,300	7,650	21,650	9,727
	2.00 - 2.99	1	24,800	17,850	6,950	3,123
9/1/2002 - 8/31/2004	3.00 - 3.99	2	22,550	17,850	4,700	2,112
	4.00 - 4.99	1	20,350	22,950	-2,600	0
	6.00+	13	11,000	57,893	-46,893	0
	0.00 - 0.99	1	28,000	7,650	20,350	9,143
	2.00 - 2.99	1	23,500	17,850	5,650	2,539
9/1/2004 - 8/31/2006	3.00 - 3.99	3	20,850	21,250	-400	0
	4.00 - 4.99	1	19,650	22,950	-3,300	0
	6.00+	21	3,188	80,957	-77,769	0
	0.00 - 0.99	2	26,600	5,100	21,500	9,660
9/1/2006 - 8/31/2008	1.00 - 1.99	1	24,100	12,750	11,350	5,100
	6.00+	1	3,850	77,825	-73,975	0
9/1/2008 - 8/31/2010	6.00+	4	3,438	66,085	-62,648	0
Grand Total		**836**	**$20,092**	**$51,143**	**-$31,050**	**$1,704**
Current Retirees Age 67 or Older and Currently Receiving Premium Reimbursement						**1,424,393**
Overall Total						**15,999,483**

[1] The Average Cumulative Contributions in each row is the average of the Cumulative Contribution amounts, from Exhibit A, Column (B), for all retirees in the same row (i.e., the Retirees whose Date of First Contribution falls within the same two-year band and who have the same number of years of premium reimbursement), adjusted by subtracting out the average of the Cumulative Contribution amounts attributable to the period during which each Retiree in the same row attained age 67 through April 30, 2025 ("Contributions After Age 67"). Contributions After Age 67 are subtracted out because Exhibit A, Column (B) includes contributions through April 30, 2025.

To determine individual retirees' Contributions After Age 67: locate the retiree's date of turning age 67 in the applicable date range in the first column of Exhibit A, and the corresponding Cumulative Contribution amount in Column (B) of Exhibit A. That amount is the retiree's Contributions After Age 67. Retirees are assigned their Contributions After Age 67 amount regardless of the specific date that they turned age 67 within the one-year period in the first column of Exhibit A.

Example: In the row for Date of First Contribution from 9/1/2000-8/31/2002 with 1.00-1.99 Years of Premium Reimbursement, the **$26,400** Average Cumulative Contributions amount is determined by taking the average of the Cumulative Contribution amounts from Exhibit A, Column (B), for each of the 2 retirees whose Date of First Contribution was from 9/1/2000-8/31/2002 with 1.00-1.99 Years of Premium Reimbursement, and subtracting out the average of those 2 retirees' Contributions After Age 67. The following Table sets out the details of this example:

Retiree	Date of First Contribution	(A) Cumulative Contribution (from Exhibit A, Column (B))	Date at Age 67	(B) Cumulative Contributions Age 67 and After (from Exhibit A, Column (B))	(A) - (B) Cumulative Contributions to Age 67
1	09/01/2001	32,300	08/01/2023	6,900	25,400
2	09/01/2001	32,300	06/01/2024	4,900	27,400
				Average	**26,400**

[2] The Average Cumulative Premium Reimbursement in each row is the average of the Cumulative Premium Reimbursement amounts, calculated at **85%** of the maximum, as reflected in Exhibit B, Column (C), for all Retirees in the same row (i.e., for all Retirees whose Date of First Contribution fall within the same two-year band and who have the same number of years of premium reimbursement).

Example: In the row for Date of First Contribution from 9/1/2000-8/31/2002, with 1.00-1.99 Years of Premium Reimbursement, the **$10,200** Average Cumulative Premium Reimbursement amount is determined by taking the average of the Cumulative Premium Reimbursement amounts, from Exhibit B, Column (C), for each of the 2 Retirees whose Date of First Contribution was from 9/1/2000-8/31/2002, with 1.00-1.99 Years of Premium Reimbursement. The following Table sets out the details of this example:

Retiree	Date at Age 67	Cumulative Premium Reimbursement (from Exhibit B, Column (C))
1	08/01/2023	12,750
2	06/01/2024	7,650
	Average	**10,200**

The Trust Office (Coast Benefits) will be mailing out individualized statements with each participant's assigned allocation over the coming weeks. If you have any questions, please call the Trust Office at (800) 886-7559.

WL:tl
Enclosure

Exhibit A

Employee Contributions

Participant's Date of First Contribution[1]	(A) Monthly Contribution Amount (10 months per year)[2]	(B) Cumulative Contribution (10 x (A)) from Date of First Contribution to 4/30/2025[3]
<9/1/1986	$0	$39,600
9/1/1986 - 8/31/1987	35	39,600
9/1/1987 - 8/31/1988	35	39,250
9/1/1988 - 8/31/1989	35	38,900
9/1/1989 - 8/31/1990	35	38,550
9/1/1990 - 8/31/1991	35	38,200
9/1/1991 - 8/31/1992	55	37,850
9/1/1992 - 8/31/1993	55	37,300
9/1/1993 - 8/31/1994	55	36,750
9/1/1994 - 8/31/1995	55	36,200
9/1/1995 - 8/31/1996	55	35,650
9/1/1996 - 8/31/1997	55	35,100
9/1/1997 - 8/31/1998	55	34,550
9/1/1998 - 8/31/1999	55	34,000
9/1/1999 - 8/31/2000	55	33,450
9/1/2000 - 8/31/2001	60	32,900
9/1/2001 - 8/31/2002	60	32,300
9/1/2002 - 8/31/2003	60	31,700
9/1/2003 - 8/31/2004	70	31,100
9/1/2004 - 8/31/2005	70	30,400
9/1/2005 - 8/31/2006	70	29,700
9/1/2006 - 8/31/2007	85	29,000
9/1/2007 - 8/31/2008	100	28,150
9/1/2008 - 8/31/2009	100	27,150
9/1/2009 - 8/31/2010	100	26,150
9/1/2010 - 8/31/2011	100	25,150
9/1/2011 - 8/31/2012	100	24,150
9/1/2012 - 8/31/2013	125	23,150
9/1/2013 - 8/31/2014	125	21,900
9/1/2014 - 8/31/2015	150	20,650
9/1/2015 - 8/31/2016	150	19,150
9/1/2016 - 8/31/2017	150	17,650
9/1/2017 - 8/31/2018	175	16,150
9/1/2018 - 8/31/2019	180	14,400
9/1/2019 - 8/31/2020	185	12,600
9/1/2020 - 8/31/2021	190	10,750
9/1/2021 - 8/31/2022	195	8,850
9/1/2022 - 8/31/2023	200	6,900
9/1/2023 - 8/31/2024	250	4,900
9/1/2024 - 4/30/2025[2]	300	2,400

[1] Participants are assigned the applicable Cumulative Contributions amount in Column (B) if their Date of First Contribution falls within the respective one-year date range.

[2] Contributions were collected for 8 months from September 2024 through April 2025.

[3] Based on the Date of First Contribution to the Plan, each participant is assigned their respective Cumulative Contribution, regardless of the specific date that contributions began within the one-year period. In each row, the Cumulative Contribution amounts assume contributions are made to the Plan from the earliest Date of First Contribution for that row through April 2025 and reflect changes in contribution rates over time.

Exhibit B

Retiree Premium Reimbursement

Retiree's Date of Benefit Commencement at Age 67[1]	(A) Monthly Maximum Premium Reimbursement[2]	(B) Cumulative Maximum Premium Reimbursement (12 x (A)) from Date of Benefit Commencement to 6/30/2025[3]	(C) Cumulative Premium Reimbursement (85% x (B)) from Date of Benefit Commencement to 6/30/2025[4]
Pre 1/1/2009	N/A	$108,360+	$92,105+
1/1/2009 - 12/31/2009	700	108,360	92,105
1/1/2010 - 12/31/2010	700	99,960	84,965
1/1/2011 - 12/31/2011	600	91,560	77,825
1/1/2012 - 12/31/2012	556	84,360	71,705
1/1/2013 - 12/31/2013	556	77,688	66,034
1/1/2014 - 12/31/2014	556	71,016	60,363
1/1/2015 - 12/31/2015	556	64,344	54,692
1/1/2016 - 12/31/2016	556	57,672	49,021
1/1/2017 - 12/31/2017	500	51,000	43,350
1/1/2018 - 12/31/2018	500	45,000	38,250
1/1/2019 - 12/31/2019	500	39,000	33,150
1/1/2020 - 12/31/2020	500	33,000	28,050
1/1/2021 - 12/31/2021	500	27,000	22,950
1/1/2022 - 12/31/2022	500	21,000	17,850
1/1/2023 - 12/31/2023	500	15,000	12,750
1/1/2024 - 12/31/2024	500	9,000	7,650
1/1/2025 - 06/30/2025[2]	500	3,000	2,550

[1] Retirees are assigned the applicable Cumulative Premium Reimbursement in Column (C) if the date they turn age 67 falls within the respective calendar year. Retirees are assigned the applicable amount regardless of the actual date within the calendar year in which they turn age 67.

[2] In 2025, Premium Reimbursements were paid out for six months, from January through June 2025.

[3] In this Column, it is assumed that regardless of when the retiree turned age 67 in a calendar year, the maximum premium reimbursements were paid for that entire calendar year and each year thereafter, until June 30, 2025, when benefits were suspended.

[4] Each retiree's Cumulative Premium Reimbursement is assumed to be **85%** of the respective amount in Column (B). The amounts from this Column (C) are used to calculate the Average Cumulative Premium Reimbursement amounts in Chart 2, Column (B), and thus are used in determining participants' Allocated Amounts.