Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees

Plan Document and Summary Plan Description

January 1, 2026

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Introduction

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

In the past year, the Montebello Teachers Association Retiree Supplemental Health Plan (the "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 of the Plan implemented a temporary suspension of benefits while it conducted an actuarial study. Ultimately, given that no future contributions would come into the Plan, the Board of Trustees ("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 Participants on September 25, 2025. The Actuarial Report details how these calculations were made and is also available on the Trust Office's website at . You may also request in writing a paper copy of the Actuarial Report at no charge from the Trust Office.

Under prior versions of the Plan, benefits were available only to retirees who had reached age 67 and satisfied other eligibility requirements. Due to the wind down of the Plan, it became necessary to redesign and amend the Plan so that Active Employees (as well as retirees) could receive benefits. Thus, the January 1, 2023, Summary Plan Description and Plan Document of the Plan, has been amended and restated. Effective January 1, 2026, there are now two separate plans. This new Plan Document and Summary Plan Description for the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees allows Active Employees (and certain Retired Participants who work for the District on or after January 1, 2026) to receive their Allocated Amount through the payment of benefits.

This booklet is both the Plan Document and the Summary Plan Description (hereafter "SPD") of the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees. It serves to describe the rules of the Active 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.

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 Employee. An Active Employee is a person who is a non-retired employee of the District, covered under the MTA collective bargaining agreement as of April 30, 2025, or an AMSA member who was formerly a MTA member and continued to make contributions to the Plan through April 30, 2025. **Active Employees are not necessarily Participants in the Plan.**

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.[1] 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.

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[1] 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.

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.

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

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

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.

HRA. The term "HRA" means Health Reimbursement Account. An HRA is a type of employer-funded health plan that reimburses employees for qualified medical expenses (or may pay the expenses directly through a debit card).

Member. The term "Member" means a MTA 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 April 30, 2025, is not a Member of MTA and does not pay union dues. A Non-Member has no Allocated Amount.

Other Group Health Coverage. The term "Other Group Health Coverage" means another group health plan (not including this Plan or an HRA), that provides minimum value, as defined in 26 U.S.C. § 36B(c)(2)(C)(ii), as amended and further defined in regulations, and which provides medical benefits that do not consist solely of dental, vision, and/or fertility benefits. For example, your group health coverage with the District is generally considered "Other Group Health Coverage."

In order to be eligible to receive benefits under this Plan, you must sign a declaration attesting that you had Other Group Health Coverage (and providing the name of the Other Group Health Coverage), when you incurred Covered Expenses that you submit for reimbursement. You can designate only one group health plan as your Other Group Health Coverage.

- **Note: Individual Market coverage (such as through Covered California), Medicare, and individual market polices provided under an employer payment plan are not Other Group Health Coverage, as they are not group health plans.**

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

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

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.

Retired Participant. In this Plan, the term "Retired Participant" means an MUSD retiree who satisfies eligibility conditions for benefits under Article 2, sections 1 and 2 of the Retiree Plan (including the definition of Covered Retiree in Article 1 of the Retiree Plan), except that the retiree is (or becomes) employed by the District, in any capacity, on or after January 1, 2026, and therefore, has become ineligible for benefits under the Retiree Plan. Such a Retired Participant is eligible for benefits under this Active Plan if he or she has an Allocated Amount that has not been reimbursed in full.

Retiree Plan. The term "Retiree Plan" means the Montebello Teachers Association Retiree Supplemental Health Plan for Retired Employees.

Trust Agreement. The term Trust Agreement means the Second Restated Agreement and Declaration of Trust Providing for the Montebello Teachers Association Retiree Supplemental Health Plan.

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

Active Employees as of April 30, 2025:

To be a Participant eligible for benefits in this Plan, an Active Employee must:

(1) have been a full-time employee of the District on April 30, 2025; and

(2) have been employed in a position covered under the MTA collective bargaining agreement on April 30, 2025 (or was an administrator under AMSA and former member of the MTA bargaining unit, who paid contributions to the Plan and administrative fees through April 30, 2025); and

(3) have been a member in good standing with MTA as of April 30, 2025 (or an administrator under AMSA); and

(4) have been a dues paying member of the MTA (or an AMSA member) who paid Plan contributions from the beginning of full-time employment with MUSD (or from September 1986, if full-time employment with MUSD started before then) through April 30, 2025, or paid such dues (or administrative fees) and contributions, including interest, for the time period missed and made such payment of retroactive contributions and interest on or before April 30, 2025; and

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

If you were an Active Employee as of April 30, 2025, you are eligible for benefits from the Plan only if you satisfy the above conditions and have an Allocated Amount (or a portion of an Allocated Amount) that has not yet been reimbursed by the Plan.

Active Employees who permanently ceased to pay dues to MTA prior to April 30, 2025, or permanently ceased to make contributions to the Plan prior to April 30, 2025 (or prior to attainment of age 67, 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.

Retired Participants as of June 30, 2025:

If you were a Retired Participant (as defined in Article 1) as of June 30, 2025, who is employed or becomes employed by the District, in any capacity, on or after January 1, 2026, you will be eligible to receive the remainder of your Allocated Amount, if any, through the payment of benefits under this Plan, if you satisfy the following conditions:

1. You satisfy the eligibility requirements of Article 2, sections 1 and 2 of the Retiree Plan, except that you are employed (or become employed) by the District, in any capacity (including as a substitute teacher), on or after January 1, 2026;

2. You have an Allocated Amount, the entirety of which has not been reimbursed.

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 Active Employees and Retired Participants who are eligible for benefits under section 1 of this Article 2, and satisfy each of the following conditions:

1. You have completed an enrollment form for this Plan (i.e., the Active Plan) and submitted it to the Trust Office; and

2. You maintain an account in any qualified financial institution (all fees charged by the

qualified financial institution must be paid by the Participant/Retired Participant and are not included in the reimbursement benefits offered by this Trust); and

3. You have an Allocated Amount, the entirety of which has not yet been reimbursed; and

4. You are enrolled in Other Group Health Coverage (as fully defined in Article 1)[2], which provides minimum value, as defined in 26 U.S.C. § 36B(c)(2)(C)(ii), and which provides medical benefits that do not consist solely of excepted benefits (dental, vision and/or fertility benefits); and

5. You have provided the Trust Office with evidence, satisfactory to the Trustees, that you are enrolled in Other Group Health Coverage (as defined in Article 1), typically through the completion of a declaration or on a claim form; and

6. You have not affirmatively opted out of benefits from this Plan (see Article 3, section 3 for more information); and

7. You provide any other information or documentation needed by the Trust Office to reimburse your claims.

Section 3 Examples

Example No. 1 – Full Time Educator

Michelle is a full-time educator with MUSD. Michelle has been a member of the MTA and paid member dues and plan contributions during her entire career with MUSD. Michelle's date of first contribution to the Plan was September 1, 2004, and she has an Allocated Amount of $13,487.00.

While employed by MUSD, Michelle and her children are covered under the District's Plan.

To the extent Michelle has out-of-pocket medical costs that qualify as Covered Expenses (such as copayments or coinsurance for doctor's appointments, hospital stays, or prescription drugs) for herself or her Children she can submit a claim to be reimbursed by the Plan for those expenses, subject to her Allocated Amount. Please see Article 4, section 3 for a description of Covered Expenses.

Once she has received reimbursements in the full amount of her Allocated Amount, no further benefits will be payable to Michelle, and she will cease being a Participant in the Plan.

Note: Under current District rules, MTA bargaining unit members who retire from District after having attained age 55 and accruing at least 15 years of service can qualify for retiree health benefits from the District, whereby the District reimburses you for all or part of the premium that you pay for retiree health insurance through CalPERS until you reach age 67.

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[2] Individual Market coverage (e.g., through Covered California), Medicare, and individual market polices provided under an employer payment plan are not Other Group Health Coverage because they are not group health plans.

However, starting at age 67, MUSD no longer contributes toward the cost of retiree health coverage. Thus, when Michelle reaches age 67, she will receive no assistance from the District for the cost of retiree health coverage, and she will be fully responsible for the cost of any retiree coverage.

Example No. 2 -- Full-Time Educator, Spouse in Different Health Plan

Fernando is a full-time educator with MUSD. Fernando has been a member of the MTA and paid member dues and Plan contributions during his entire career with MUSD. Fernando's date of first contribution to the Plan was September 1, 2008, and he has an Allocated Amount of $ 12,049.00.

Fernando and his Children are covered under the District's Plan. However, Fernando's spouse is not covered under the District's Plan, and is, instead, covered under health insurance offered by the spouse's employer.

To the extent Fernando has out-of-pocket medical costs that qualify as Covered Expenses (such as copayments or coinsurance for doctor's appointments, hospital stays, or prescription drugs) for himself or his Children, he can submit a claim to be reimbursed by the Plan for those expenses, subject to his Allocated Amount. Please see Article 4, section 3 for a description of Covered Expenses.

However, Fernando cannot submit any of his spouse's Covered Expenses for reimbursement from this Plan, because his spouse is not enrolled in the same Other Group Health Coverage as Fernando. Please see Article 4, section 4 for more information about whose Covered Expenses can be reimbursed.

Section 4. Non-Members

Non-Members who joined the Montebello Teachers Association prior to April 30, 2025, are eligible for benefits under the Plan, if the following conditions were satisfied before April 30, 2025, and they otherwise satisfy the requirements of Article 2, sections 1 and 2:

1) They elected to become a dues-paying member of the MTA continuously without interruption since first becoming a member; and

2) They paid the required monthly dues (including Plan contributions) to the MTA 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 on or before April 30, 2025.

Article 3: Loss of Eligibility

Section 1. Circumstances That Result In Loss of Eligibility

Participants and Retired Participants in the Plan lost Participant status (i.e., are no longer a Participant) and are not 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.

In addition to the above:

1) A Participant or Retired Participant who dies on or after June 1, 2025, will cease to be a Participant/Retired Participant as of the date of death, and no further benefits will be payable from the Plan, except that if the Participant/Retired 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 (or Retired Participant's) surviving Beneficiary and/or spouse, as applicable, as described in Article 4, section 5 of this SPD.

2) A Participant or Retired Participant who died prior to June 1, 2025, is not a Participant and is not eligible for benefits under this Plan, 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 Article 4, section 5 (Death Benefits) and the Claims and Appeals Procedures in Article 6 of this SPD.

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

4) If you elect to "opt-out" of Plan coverage by completing the Opt-Out of Coverage Form you will not be eligible for any further reimbursement benefits from the Plan, even in the future. If you Opt-Out of coverage, you cannot revoke your opt-out, and you will be unable to be reimbursed for any Covered Expenses.

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. 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:

1. If you fail to complete the Plan's enrollment form, you will not be eligible for benefit reimbursements until you complete such form and return it to the Trust Office.

2. If you are not enrolled in Other Group Health Coverage (as defined in Article 1) or you fail to satisfactorily complete a Declaration of Enrollment in Other Group Health Coverage, you will not be eligible for benefits from the Plan. However, once you are enrolled in Other Group Health Coverage and have completed the Declaration of Enrollment in Other Group Health Coverage, this restriction will be lifted and you will be eligible for benefit reimbursements, if you otherwise satisfy eligibility requirements for benefits.

3. 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.

4. If you permanently left District employment prior to April 30, 2025, (or prior to retirement, if earlier), or discontinued MTA membership prior to April 30, 2025, or did not pay all contributions owed to the Plan through April 30, 2025 (or age 67, if earlier), you will cease participation and not be eligible for benefits from the Plan. See section 1 of this Article 3, Loss of Eligibility, for more information.

5. 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 or surviving spouse may be eligible for death benefits as described in Article 4, section 5.

6. If you submit an Opt-Out Form in which you make an election to permanently opt out of coverage from this Plan, you will not be eligible for any further benefits from this Plan, and you cannot revoke your opt-out election. See section 3 below for more information.

Recoupment or Offset of Overpaid Benefits. If the Plan overpays benefits to a Participant or beneficiary, the Trust Office will 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.

Section 3. Annual Opt-Out Form

On an annual basis and upon your leaving employment with the District, the Trust Office will provide you an "Opt-Out Form" that allows you to permanently opt out of benefits from the Plan. This is a form that the Plan is legally required to provide to you. You must notify the Trust Office that you have stopped working for the District for the Plan to provide you an Opt-Out Form.

If you elect to complete the form and "opt-out" of Plan coverage, it means that you will not be eligible for any further reimbursement benefits from the Plan, even in the future. If you Opt-Out of coverage, you cannot revoke your opt-out, and you will be unable to be reimbursed for any Covered Expenses.

Please be very careful and do not complete the Opt-Out Form unless you intend to forfeit all benefits, including death benefits, from the Plan.

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 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 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 September 1, 2006. Her Allocated Amount is $12,896.

Chart 2 – Chart 2 applies to Participants who were age 67 or older on June 30, 2025, and who previously received premium reimbursements under the Retiree Plan. Chart 2 would apply, for example, to a Retired Participant who commenced benefits under the Retiree Plan, but has since returned to employment with the District. 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 September 1, 2003, and he has previously received 2.50 years of premium reimbursements. Ben's Allocated Amount is $3,123.

For Retired Participants 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 and Retired 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 or Retired 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.

[4] Participants and Retired Participants 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.

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/or 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 and Retired Participants who have an Allocated Amount that has not yet been fully disbursed by the Plan. Specifically, the Plan only reimburses Participants' (and Retired Participants') 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 Other Group Health Coverage that covers the Participant and/or one or more of the Participant's Dependents. Remember that your Other Group Health Coverage is the health plan or insurance that you have designated as your Other Group Health Coverage (as defined in Article 1). **Note that this Plan does not reimburse insurance premiums for group health plans other than for your Other Group Health Coverage.**

    - For Active Participants, your Other Group Health Coverage would typically be your health plan provided by the District through CalPERS.

    Note that, this Plan does not reimburse insurance premiums that you (or your spouse) paid with pre-tax income (such as from an HRA).

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

[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.

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 for coverage of the Participant and/or his or her legal spouse while eligible for benefits under this Plan.[6] 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. Moreover, once your Allocated Amount has been disbursed/reimbursed in full, no further benefits will be payable to you.

Section 4. Whose Covered Expenses Can Be Submitted for Reimbursement

As an active Participant or a Retired Participant with an Allocated Amount, you can submit claims for your own Covered Expenses. You can also submit claims for Covered Expenses of one or more of your Dependents (i.e., your legal spouse and Child(ren)), **but only if the Dependent is enrolled in the same Other Group Coverage that you are enrolled in**. (For an illustration of this rule, see Example 2 in Article 2, section 3). However, your total benefit 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.

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[6] A Participant's legal spouse must be enrolled in the same Other Group Health Coverage as the Participant in order for the spouse's LTC insurance premiums to be reimbursable from the Plan.

Due to the cost 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 case, 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) or 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 his or her 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 Participants or Retired Participants, who died between January 1, 2023 and May 31, 2025, and for whom a death benefit has not previously been paid by the Plan, death benefits can be paid to

the Beneficiary(ies) of such deceased Participant or Retired Participant, provided that a claim is received by the Trust Office by May 31, 2026, in the following two circumstances:

1. If such a Participant/Retired Participant who satisfied the rules for eligibility as a Participant/Retired Participant 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 a Retired Participant 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 a Retired Participant previously 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 Available from MUSD

Currently, 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 retiree health plans. Such reimbursements are available until a retiree attains age 67.

Beginning at age 67 retirees have the option to continue enrollment in their CalPERS health plan. However, at this point, the MUSD has no further involvement in paying for retiree health coverage, and the retiree will be responsible for the full premium on their CalPERS health plan going forward. Alternatively, a retiree age 67 or older has the option to look outside of CalPERS for health coverage. In either case, MUSD does not contribute to the cost of retiree health coverage once you turn age 67.

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

IMPORTANT: Before any claims can be reimbursed by the Plan, there are two things you need to do:

1. You must complete the Plan's enrollment form. None of your claims can be reimbursed unless you have submitted a new completed enrollment form to the Trust Office.

2. You must provide the Trust Office, on at least an annual basis, or as may otherwise be requested by the Trust Office, a signed declaration of Other Group Health Coverage in which you attest that: you are enrolled in Other Group Health Coverage (not including this Plan or an HRA), that provides minimum value and which provides medical benefits that do not consist solely of dental and/or vision benefits. See definition of Other Group Health Coverage in Article 1. The Trust Office will send you declaration of Other Group Health Coverage, at least annually (and/or may include such declaration on its claim form), and will suspend benefit reimbursements until it receives a completed form from you.

Section 1. Deadline to Submit Claims for Reimbursement

In order to present a claim for benefits, you 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).

Note, however, that to submit claims for Covered Expenses incurred in 2024 or 2025, you satisfy the following as of the date you incurred the Covered Expense (i.e., as of the date of service):

1. Have had Other Group Health Coverage and have completed the necessary declaration designating the Other Group Health Coverage in place at the time the expense was incurred; and

2. have been an employee of the District paying MTA dues (or an AMSA member paying administrative expenses) at the time the expense was incurred.

Section 2. 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 3. Three Ways to Submit Claims for Reimbursement

There are three ways you can submit claims for reimbursement: (1) by paying the claim with a Debit Card issued to you by the Plan/Trust Office ; (2) by submitting an electronic claim using the Wex platform; or (3) by submitting a paper claim (via mail or fax) to the Trust Office. All Participants must register on the Wex platform. Doing so will also enable you to see the balance remaining in your Allocated Amount.

If your electronic or written claim 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.[7] 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. You must submit an electronic or paper claim (with supporting documentation) to be reimbursed for these international medical expenses. Imported prescriptions (brought in from, or ordered and shipped from, another country) generally are not covered.

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:

1. Over-the-counter ("OTC") drugs and medicines, such as allergy medications, pain relievers, supplements, and certain dermatological products;
2. Insurance premiums;
3. 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).
4. 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

[7] 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.

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

Once you have registered an account on the Wex Platform, you can then submit electronic 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 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 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. 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 C below.

Claims Paid by Plan Debit Card

As discussed in section 3 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 to substantiate 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. 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).

Claims Submitted on the Wex Platform or by Mail

As detailed below. The supporting documentation that you will need to submit depends on whether you are seeking reimbursement for:

- Covered Expenses (Other Than Insurance Premiums)
- Monthly Insurance Premium 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 Insurance Premiums:*

For each claim to reimburse Covered Expenses other than insurance premiums, 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 the addition of a new Dependent), 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, 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 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 Retiree 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.

For this Article 6 only, the term "Participant" shall also include "Retired Participants."

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

(a) **Standard Claim Decision - Timing**. The Trust Office shall consider each 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 Beneficiary 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 that occurred between January 1, 2023 and May 31, 2025, claims must be filed by May 31, 2026.

(ii) For deaths that occur on or after June 1, 2025, 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 other person who claims to be entitled to reimbursement under this Plan, must follow the provisions 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) A 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 herein.

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 Diego, 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 relate 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 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, shall 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 Participant's/Retired Participant'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 employer 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.

8.1. 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.

8.2. 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.

8.3. 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.

8.4. Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you

should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone correctly. 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**.

8.5. 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.

8.6. 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 Active Employees.

Plan Type. This is a welfare plan that reimburses medical premium costs 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
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, on which employees are represented. 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 Administrative Office for the Plan:

Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
(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.