mta
Montebello Teachers Association
Retiree Supplemental Health Plan
3530 Camino Del Rio North * Suite 110 * San Diego, CA 92108 * 800-886-7559

MTA - RSHP – Active Employee Plan Enrollment Information

As you may be aware, Coast Benefits administers the Montebello Teachers Association Retiree Supplemental Health Plan (referred to as the "Retiree Plan" or "Trust"). In the past year, the Trust has undergone many changes. On April 30, 2025, all contributions to the Trust ceased. As a result, the Board of Trustees of the Trust implemented a temporary suspension of benefits while it conducted an actuarial study. Ultimately, given that no future contributions will be paid into the Trust, the Board of Trustees made the difficult decision to begin winding down the Trust. Under prior versions of the Retiree Plan, benefits were available only to retirees who had reached age 67 and satisfied other eligibility requirements. Due to the winding down of the Trust, it became necessary to redesign and amend the Retiree Plan so that Active Employees (as well as retirees) could receive benefits. **Effective January 1, 2026**, there are now two separate plans. You are being provided this enrollment information as a Participant in the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees (the "Active Plan"). The Active Plan allows Active Employees (and certain Retired Participants who worked for the District after June 30, 2025) to receive their Allocated Amount through the payment of benefits.

The Active Plan is a VEBA, short for Voluntary Employees' Beneficiary Association (VEBA), that is tax exempt under section 501(c)(9) of the Internal Revenue Code. The Active Plan is not an HSA or a FSA. The Active Plan will reimburse certain out-of-pocket medical costs, incurred by Participants, that qualify as Covered Expenses (such as, copayments or coinsurance for doctor's appointments, hospital stays or prescription drugs) Participants can submit a claim to be reimbursed by the Active Plan for those expenses, subject to their Allocated Amount.

Each Participant's Allocated Amount in the Active Plan, **as of January 1, 2026**, is 44.93% of: the Participant's estimated total contributions paid into the Active Plan, minus the estimated total premium reimbursements (if any) that the Participant has already received from the Active Plan. 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 Active Plan. An individual can have only one Allocated Amount. If eligible for benefits under both the Retiree Plan and the Active Plan, the individual will be in the Retiree Plan, if the Participant is not working for the District. **Note**: However, if you retired after June 30, 2025, you are in the Active Plan and are not currently eligible for benefits in the Retiree Plan.

Please review the Plan Document and Plan's Summary Plan Description for Active Employees (Active SPD) for a more detailed explanation of the Active Plan and its benefits, including the Covered Expenses and Allocated Amount. (The Active SPD is included with your enrollment materials.)

As an Active Employee, you have a couple of different reimbursement options in this Active Plan.

To present a claim for benefits, the Participant must submit a claim with all required documentation supporting the claim, by the **annual claims deadline**, **which is three (3) months after the end of the calendar year in which you paid the Covered Expense (i.e., no later than March 31st,** for expenses you paid during the prior calendar year). **Claims submitted after this March 31st deadline** (i.e., more than 3 months after the end of the calendar year in which you paid the Covered Expense), **will not be eligible for reimbursement**.

There is one exception to the claim's 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 to December 31, 2025).

The enrollment materials include:

1. **Enrollment Form** – to be completed and returned to Coast Benefits.
2. **Beneficiary Designation Form** – used to designate the primary and contingent beneficiaries that would be entitled to receive the value of your account in the event of your death.
3. **MTA – RSHP Opt-Out Form -** Only return if you are Opting Out of the Plan forever (no Allotted Amount will be paid)
4. **Declaration of Other Group Health Coverage -** Please mark which MUSD health plan coverage you have (Needs to be returned in order to active the Account)
5. **Summary of Benefits and Coverage**
6. **Plan Document and the Summary Plan Description for Active Employees (SPD)** – The SPD describes the rules of the Active Plan, including benefits available under the Active Plan.

Should you have additional questions you may contact Coast Benefits at 619-280-2009 or 800-886-7559. Customer Service Representatives are available Monday through Friday between 8:30 a.m. and 5:00 p.m. PST on any business day. Additional information regarding the Active Plan can be found on the Trust's Office's website at https://coastbenefits.com/your-plan/montebello-teachers-association-3n/.

Very truly yours,
COAST BENEFITS

Montebello Teachers Association
Retiree Supplemental Health Plan

3530 Camino Del Rio North * Suite 110 * San Diego, CA 92108 * 800-886-7559

ENROLLMENT FORM for ACTIVE EMPLOYEES

(Please Print)

I. Qualified Participant Information

Social Security Number | Last Name | First Name

Street Address | City | State | Zip

Phone Number | Date of Birth (mm/dd/yyyy) | Personal Email Address

II. Dependent/Type of Coverage Information

Your Spouse and Dependents are eligible to file claims of reimbursement under the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees. Please provide a marriage certificate and birth certificate/adoption paperwork for all dependents (up to age of 26). Omitting any information will delay the reimbursement for you and any applicable dependents. Federal law requires that if you are married, benefits payable under the Plan by reason of your death must be paid to your spouse and dependents (listed below) until the funds in your account are $0.

	Last Name	First Name	MI	Sex (M/F)	Date of Birth (mm/dd/yyyy)	Social Security Number
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

III. Bank Authorization

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Bank Account Number: _____

Type of Account: ☐ Checking** ☐ Savings

**Please submit a voided check with your completed form if checking account.

Signature: _____ Date: _____

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. 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.

I understand as an Active Employee I am 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.

The information herein is complete and correct to the best of my knowledge. I authorize Coast Benefits to enroll myself, my spouse (if applicable), and dependents (if applicable), based on the information that is stated in this form.

Signature: _____ Date: _____

Please submit your completed form to the MTA Retiree Supplemental Health Plan
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
mtarshp@coastbenefits.com
Phone (800) 886-7559
Fax (619) 501-3250

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BENEFICIARY DESIGNATION FORM

I, _____, in accordance with the terms of the of the Montebello Teachers Association Retiree Supplemental Health Plan (hereinafter referred to as the "Plan")", do hereby name as Beneficiary thereunder to receive the remaining amount of my Allocated Amount in the event of my death:

Primary Beneficiary Designation: Percentage of Remaining Allocated Amount 100 %

Primary Beneficiary	Relationship	Date of Birth	Social Security Number

Address: _____
Street City State Zip Code

Check One
Phone: _____ ☐ Home ☐ Cell Email: _____

Contingent Beneficiary Designation: Percentage of Remaining Allocated Amount _____%

Contingent Beneficiary 1 (*optional*)	Relationship	Date of Birth	Social Security Number

Address: _____
Street City State Zip Code

Check One
Phone: _____ ☐ Home ☐ Cell Email: _____

Percentage of Remaining Allocated Amount _____%

Contingent Beneficiary 2 (*optional*)	Relationship	Date of Birth	Social Security Number

Address: _____
Street City State Zip Code

Check One
Phone: _____ ☐ Home ☐ Cell Email: _____

I further reserve the privilege of changing the Beneficiary herein named at any time or times without the consent of any such beneficiary. This designation is made upon the following terms and conditions:

1. The word Beneficiary as used herein shall include the plural, Beneficiaries, as applicable.

The benefit to be paid to the Beneficiary is outlined in the Plan Document and Summary Plan Document (SPD) and is only available to the Beneficiary up to my remaining Allocated Amount. This benefit ceases to exist once I have collected my Allocated Amount in the Plan. I understand that this Beneficiary Designation Form hereby revokes and supersedes any and all prior beneficiary designations made by me with respect to Plan.

Participant: _____ Date: _____
Please print clearly

Signature: _____
Please sign in blue or black ink

Spouse's Consent (to be completed only if Participant's Spouse **is not** the Primary Beneficiary):

I hereby consent to the beneficiary designation made on this Beneficiary Designation Form. I understand that:

1. I would receive the benefit payable under the Plan on account of my spouse's death if I do not consent to the Primary Beneficiary Designation made above.
2. The beneficiary will be entitled to the death benefit outlined in the Plan's SPD on behalf of my spouse upon his or her death.
3. My spouse's election cannot be effective without my consent.
4. My consent is irrevocable unless my spouse revokes his or her beneficiary designation.

Spouse: _____ Date: _____
Please print clearly

Signature: _____
Please sign in blue or black ink

*Notarization is only necessary if Participant's Spouse **is not** the Primary Beneficiary

State of California
County of _____ }

On _____, before me, _____, Notary Public, personally appeared

_____

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SIGNATURE_____

PLACE NOTARY SEAL ABOVE

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December 29, 2025

Notice of Ability to Permanently Opt Out of Plan Benefits

As a participant in the Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan" or the "Trust"), you have the right to permanently "opt out" of reimbursement benefits from the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees (Active Plan) and its Trust.

For more information about the Plan and the benefits available under the Plan, see the Plan Document and Summary Plan Description of the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees.

Ability to Permanently Opt Out of Reimbursement Benefits.
We encourage you to claim the reimbursement benefits available to you by submitting claims for Covered Expenses, as we want you to receive your Allocated Amount in full. However, we are required to inform you of your right to permanently opt out of Plan benefits.

Should you choose to opt out of Plan benefits by completing the Opt Out Form on the next page, **you will irrevocably terminate your benefits from this Plan and the balance of your Allocated Account will be forever forfeited to the Plan. If you opt out,** you will never be able to submit claims for reimbursement under the Active Plan or under the Montebello Teachers Association Retiree Supplemental Health Plan for Retired Employees (the "Retiree Plan").

Further, opting out of plan benefits could impact your ability to sue the Plan, its Trust, and/or the Trustees for benefits because you will have permanently forfeited your right to Plan benefits. You have the right to seek legal counsel.

The decision to permanently and irrevocably opt-out of Plan benefits is a serious decision. Please take your time to consider this decision carefully. **You will not later be able to revoke this opt out.** If you have any questions about opting out, please call the Trust Office (Coast Benefits) at (800) 886-7559.

Sincerely,

Board of Trustees
Montebello Teachers Association Retiree
Supplemental Health Plan for Active Employees

mta

Montebello Teachers Association Retiree Supplemental Health Plan

3530 Camino Del Rio North * Suite 110 * San Diego, CA 92108 * 800-886-7559

Opt Out of Plan Benefits Form

By signing below, I acknowledge my right to medical reimbursement benefits from the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees (the "Plan") up to my Allocated Amount. I understand that these benefits are generally attributable to contributions I paid to the Plan through the payment of union dues to the Montebello Teachers Association.

Despite understanding my right to benefits and my financial contributions to the Trust, by my signature below, I hereby permanently and irrevocably opt out of benefits from the Plan. I understand that as a result of opting out of all Plan benefits, I am giving up my right to request reimbursement of any Covered Expenses that I may have already paid or that I pay in the future, and my Allocated Amount (or any remaining portion thereof) is forfeited to the Plan and its Trust. I understand that this decision is irrevocable upon receipt of this signed form at the Trust Office. I further understand that my printed name below must be legible for this Opt Out Form to be valid.

_____

Printed Name Signature Date

After you complete and sign this form, please submit it to the Trust Office at:

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

*****IMPORTANT – PLEASE READ*****

By completing this form, you are permanently giving up your right to receive any future benefits from this Active Plan (and from the Retiree Plan). Your Allocated Amount (or any remaining portion thereof) will be permanently and irrevocably forfeited to the Plan, and you will not be able to be reimbursed for any portion of your Allocated Amount.

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DECLARATION OF OTHER GROUP HEALTH COVERAGE

In order to be eligible for reimbursement benefits from the Montebello Teachers Association Retiree Supplemental Health Plan for Active Employees (the "Active Plan"), you (the Participant making a claim for reimbursement of Covered Expenses) must be enrolled in Other Group Health Coverage. In addition, any Dependents (lawful spouse or Child(ren)) whose medical expenses you wish to submit for reimbursement must be enrolled in the same Other Group Health Coverage that you are enrolled in.

Other Group Health Coverage means another group health plan (not including this Plan or an Health Reimbursement Arrangement (HRA)) that provides "minimum value,"[1] as defined in Internal Revenue Code section 36B(c)(2)(C)(ii) (and its attendant regulations), and which provides medical benefits that do not consist solely of dental, vision, and/or fertility benefits.

I, _____ hereby declare, as follows:
[Name of Active Employee]

1. I am enrolled in a group health plan ("GHP") other than this Plan that satisfies the following requirements:

    a. The GHP provides minimum value as defined in Internal Revenue Code Section 36B(c)(2)(C)(ii) and regulations thereunder; and

    b. The GHP is not an HRA; and

    c. The GHP provides medical benefits that do not consist solely of dental, vision, and/or fertility benefits

2. The GHP described in paragraph 1, in which I am enrolled is:

    a. The following plan offered by the Montebello Unified School District ("MUSD") through CalPERS *(indicate the GHP in which you are enrolled)*:

        _____ Anthem Blue Cross Select HMO

        _____ Anthem Blue Cross Traditional HMO

[1] **Minimum Value.** For a GHP to provide minimum value, it means generally that, on a population basis, the GHP is expected to cover 60% or more of your medical expenses. The "Summary of Benefits & Coverage" for your other GHP should contain a statement as to whether the plan provides minimum value. If you are not sure if your GHP provides minimum value, you can contact the administrator of your group health plan or the employer providing the coverage (e.g., the Montebello Unified School District (District) or your spouse's employer, if you have coverage from your spouse's employment).

_____ Blue Shield Access+ HMO

_____ Blue Shield Trio HMO

_____ Health Net Salud y Mas HMO

_____ Kaiser Permanente HMO

_____ PERS Gold PPO

_____ PERS Platinum PPO

_____ UnitedHealthcare SignatureValue Alliance HMO

_____ UnitedHealthcare SignatureValue Harmony HMO

b. I am not enrolled in a health plan offered by the MUSD, and am instead enrolled in the following GHP that satisfies the requirements of paragraph 1:

Name of GHP:_____

3. My Dependents named below are enrolled in the same GHP that I am enrolled in (which is indicated in paragraph 2 of this Declaration).

Spouse: _____ Dependent:_____

Spouse: _____ Dependent:_____

Spouse: _____ Dependent:_____

4. I understand that I must inform the Trust Office and provide a new Declaration of Other Group Health Coverage, if the Group Health Plan in which I am currently enrolled changes, terminates, or no longer provides minimum value, or if my Dependents covered under that GHP change.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

Date Signature of Participant

Name of Active Employee/Primary Insured on GHP indicated in section 2/Participants Name:

(Please Print): _____

Social Security Number (last 4): _____

This is only a summary. The SBC sets out what the Plan reimburses you up to your **Allocated Amount.** For more information about what this Plan reimburses or to get a complete copy of the complete terms of coverage, including the Plan Document and Summary Plan Description (SPD), call 1-800-886-7559. For general definitions of common terms, see the Glossary. at www.healthcare.gov/glossary or call 1-800-886-7559 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	There is no deductible for this Plan. This Plan reimburses you up to the balance in your Allocated Amount for the cost of medical expenses (including deductibles) you have paid (and for which you didn't receive reimbursement from any other source) to the extent those medical expenses are tax deductible under Internal Revenue Code (IRC) section 213. IRC section 213 generally allows you to deduct expenses you incur for the diagnosis, cure, mitigation or prevention of disease or injury.
Are there services covered before you meet your deductible?	**Yes**	There is no Plan deductible, and thus, none for you to meet in this Plan. This Plan will reimburse your deductible costs and any other tax-deductible medical expenses that you have paid up to your **Allocated Amount**.
What is the out–of–pocket limit for this Plan?	**N/A. The Plan has no out-of-pocket limit.**	There's no out-of-pocket limit on this Plan. You will remain responsible to pay all medical expenses that exceed the balance of your **Allocated Amount**.
What is not included in the out–of–pocket limit?	**The Plan has no out-of-pocket limit**	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	**No**	The Plan will reimburse you and your eligible dependents for medical premiums and medical expenses that qualify as "medical care" under the Internal Revenue Code section 213(d), but only up to your **Allocated Amount**.
Will you pay less if you use a network provider?	**No**	This Plan does not have a network of providers. This Plan reimburses qualifying medical expenses.
Do I need a referral to see a specialist?	**No**	This Plan does not require you to obtain a referral to see the specialist you choose.
Are there services this Plan doesn't cover?	**Yes**	Some of the services this Plan doesn't cover are listed on page 5. See the SPD for additional information about **excluded services**. You can receive a copy of these documents by calling 1-800-886-7559.
This Plan reimburses medical premiums and medical expenses up to your Allocated Amount, which is generally set forth in Appendix A of the SPD (provided you satisfy the Plan's eligibility requirements).		See your SPD for more details. You can receive a copy of this document by calling 1-800-886-7559.

- **This Plan** may reimburse you for your **deductibles**, **copayments**, **coinsurance** and **balance billing** amounts, regardless of whether your provider was in-network or out-of-network. **This Plan is not your primary health insurance.** This Plan will reimburse you for out-of-pocket medical expenses, up to the balance of your **Allocated Amount**. You bear any remaining costs after your primary insurance coverage and your **Allocated Amount** balance under this Plan have been exhausted.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use an in-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using an in-network provider.	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	Your reimbursement is limited to the balance in your **Allocated Amount**. Also, this Plan only reimburses you for medical expenses that are tax deductible under Internal Revenue Code Section 213 (generally, expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury).
	Specialist visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)	Same as above under "If you visit a health care provider's office or clinic"	Same as above under "If you visit a health care provider's office or clinic"	Same as above under "If you visit a health care provider's office or clinic"
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay Network Provider	What You Will Pay Out-of-network Provider	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition	Generic drugs	Assuming the charge is lower under your primary insurance policy for "network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use a network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using a-network provider.	Assuming the charge is lower under your primary insurance policy for "network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	The drug must be prescribed or be insulin, and the amount reimbursed is limited to the balance of your **Allocated Amount**.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as above under "If you need drugs to treat your illness or condition"	Same as above under "If you need drugs to treat your illness or condition"	Your reimbursement is limited to the balance in your **Allocated Amount**. Also, this Plan only reimburses you for medical expenses that are tax deductible under Internal Revenue Code Section 213 (generally, expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury).
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay Network Provider	What You Will Pay Out-of-network Provider	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room services	Assuming the charge is lower under your primary insurance policy for "network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use a network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using a-network provider.	Assuming the charge is lower under your primary insurance policy for "network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	Your reimbursement is limited to the balance in your **Allocated Amount**. Also, this Plan only reimburses you for medical expenses that are tax deductible under Internal Revenue Code Section 213 (generally, expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury).
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you need mental health, behavioral health, or substance abuse services	Outpatient services			
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Children's Eye exam			
	Children's Glasses			
	Children's Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover: This Plan will reimburse you only for tax-deductible medical expenses (i.e., expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury). The following is a list of some expenses that would not be covered by this Plan. **(This isn't a complete list. Check your SPD and IRS Pub. 502 at http://www.irs.gov/pub/irs-pdf/p502.pdf, for other excluded services.)**

• Bariatric surgery, unless for a specific disease diagnosed by a doctor	• Health club dues and gym memberships	• Any amount exceeding your **Allocated Amount**
• Cosmetic surgery, hair removal, hair transplant, or teeth whitening services	• Medicines and drugs brought in (or ordered shipped) from another country	• Private-duty nursing care, unless providing medical, not personal or household services
• Fertility treatment expenses, unless they are tax-deductible medical expenses	• Non-prescription drugs and medicines, except insulin	• Weight loss programs, unless the treatment is for a specific disease diagnosed by a doctor

Other Covered Services: This Plan will reimburse you for tax-deductible medical expenses up to the balance in your **Allocated Amount**. The following is a list of some expenses that would be covered by this Plan. **(This isn't a complete list. Check your Plan document and IRS Publication 502, available at http://www.irs.gov/pub/irs-pdf/p502.pdf, for other covered services.)**

• Acupuncture	• Hearing aids	• Routine eye care
• Chiropractic services for medical care • Dental care (if not cosmetic)	• Non-emergency medical care outside the U.S., if the services would be tax-deductible if performed within the U.S.	• Routine foot care

There are No Rights to Continue Coverage under the Plan:

There are no rights to continue your coverage under this Plan as you and your eligible dependents are only eligible to be reimbursed for qualifying medical expenses up to your **Allocated Amount**. Once your **Allocated Amount** is exhausted, there are no further benefits payable to you from this Plan. Also, this Plan ceased accepting contributions as of April 30, 2025. You can contact the Trust Office at 1-800-886-7559. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Appeal Rights:

If you have a complaint or are dissatisfied with a denial of claim under your Plan, you have the right to **appeal the denial**. For questions about your rights, questions about this notice, or other Plan assistance, you can contact: Coast Benefits at 1-800-886-7559, 3530 Camino Del Rio North, Suite 2, San Diego, California 92108. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/.

Does this Plan provide Minimum Essential Coverage? No

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage meet the Minimum Value Standard? No.

If your plan doesn't meet the Minimum Value Standard, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Para obtener asistencia en español, llame al 1-800-886-7559.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. If you want more detail about your coverage and costs, you can get the complete terms in the SPD by calling 1-800-886-7559.

Peg is having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- **Amount owed to providers:** $12,700
- **Primary health policy pays:** $10,140
- **This Plan reimburses Patient:** $2,560*
- **Patient pays out-of-pocket:** $0*

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Deductibles	$500
Copays	$200
Coinsurance	$1,800
Limits or exclusions	$60
Total Before Reimbursement	**$2,560**
Reimbursement from this Plan	$2,560*
Total Peg would pay after reimbursement	**$0***

*Assumes Peg has a balance of at least $2,560 in her **Allocated Amount** before seeking reimbursement. See SPD, Article 4, section 3 for details.

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

- **Amount owed to providers:** $5,600
- **Primary health policy pays:** $3,780
- **This Plan reimburses Patient:** $1,820*
- **Patient pays out-of-pocket:** $0*

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**5,600**
In this example, Joe would pay:	
Deductibles	$800
Copays	$900
Coinsurance	$100
Limits or exclusions	$20
Total Before Reimbursement	**$1,820**
Reimbursement from this Plan	$1,820*
Total Joe would pay after reimbursement	**$0***

*Assumes Joe has a balance of at least $1,820 in his **Allocated Amount** before seeking reimbursement. See SPD, Article 4, section 3 for details.

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **Amount owed to providers:** $2,800
- **Primary health policy pays:** $1,700
- **This Plan reimburses Patient:** $1,100*
- **Patient pays out-of-pocket:** $0*

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Deductibles	$500
Copays	$200
Coinsurance	$400
Limits or exclusions	$0
Total Before Reimbursement	**$1,100**
Reimbursement from this Plan	$1,100*
Total Mia would pay after reimbursement	**$0***

*Assumes Mia has a balance of at least $1,100 in her **Allocated Amount** before seeking reimbursement. See SPD, section 3 for details.

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