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

MTA - RSHP – Enrollment Information for Retired Employees

As you may be aware, Coast Benefits administers the Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan" or sometimes referred to as "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.

The 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 Plan is not an HSA or a FSA. The Plan will reimburse certain out-of-pocket medical costs, incurred by Participants, that qualify as Covered Expenses (such as Medicare Part B premiums, copayments or coinsurance for doctor's appointments or hospital stays) **dating back to January 1, 2024**. Participants can submit a claim to be reimbursed by the Plan for those expenses **from January 1, 2024 to December 31, 2025**, subject to their Allocated Amount, **through March 31, 2026**.

Effective January 1, 2026, the Trust has been redesigned so that participants can receive their Allocated Amount through the payment of Plan benefits. 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. Retirees with an Allocated Amount of $0 will not be eligible for any further benefits from the Plan.

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

As a retiree, you have a couple of different reimbursement options in this 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) while you were a Covered Retiree. Note that you must have been a Covered Retiree at the time you incurred the Covered Expense to be able to submit it for reimbursement.

The enrollment materials include:

1. **Reimbursement Notice to Retired Employees**
2. **Enrollment Form** – to be completed and returned to Coast Benefits.
3. **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.
4. **Plan Document and the Summary Plan Description for Retired Employees – January 2026 (SPD)** – The SPD describes the rules of the Plan, including benefits available under the 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 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

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

Reimbursement Notice to Covered Retirees

In the past year, the Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan" or sometimes referred to as "Retiree Plan" or "Trust") has undergone many changes. On April 30, 2025, all contributions to the Plan ceased. As a result, the Board of Trustees implemented a temporary suspension of benefits while it conducted an actuarial study. Ultimately, given that no future contributions will come into the Plan, the Board of Trustees of the Plan ("Board") made the difficult decision to begin winding down the Plan.

The Montebello Teachers Association Retiree Supplemental Health Plan (the "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 Plan has been redesigned so that participants can receive their Allocated Amount through the payment of Plan benefits.

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

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

A Plan Participant with an Allocated Amount with the Plan, will be reimbursed the monthly CalPERS premiums that were paid out of your STRS checks for the months of July through December of 2025, up to your Allocated Amount. As described on page 3 and in Article 5, section 1 of the Plan Document and Summary Plan Description of the Montebello Teachers Association Retiree Supplemental Health Plan for Retired Employees (hereafter "SPD"), the Plan will reimburse by a deposit made to your designated bank account on file with the Plan. Once your Allocated Amount has been disbursed in full, no further benefits will be payable from the Plan, and you will cease to be a Plan Participant.

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

The SPD, serves to describe the rules of the Plan, including benefits available under the Plan~~.~~ The SPD can be found in this packet that was mailed to you and on the Trust's Office's website at https://coastbenefits.com/your-plan/montebello-teachers-association-3n/. Ultimately, there will be no remaining Plan assets, and the Plan will be dissolved.

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

If you are a Covered Retiree who was in pay status with the Plan at any time in 2025 (i.e., age 67 or older and received reimbursements of CalPERS premiums from this Plan in one or more months of 2025), your account has been unsuspended, and you have been reimbursed for supplemental health premiums for July 2025 through December 2025, up to your Allocated Amount.

If you are a Covered Retiree who was in pay status with the Plan at any time in 2025 and receives this notice, your full Allocated Amount has NOT been reimbursed to the bank account on file with the Trust and you will need to enroll with the Plan to activate your account.

Please note, there has been no change to your insurance coverage through CalPERS. Your health coverage will continue to be administered by CalPERS and your health insurance premium will continue to be deducted from your monthly retirement check. However, the Plan will not reimburse any portion of your monthly premium. If you have any questions regarding your retirement benefits, please reach out to CalPERS at (888) 225-7377.

If you have any questions, please call the Trust Office, Coast Benefits, at (800) 886-7559.

Sincerely,

Board of Trustees
Montebello Teachers Association Retiree Supplemental Health Plan

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ENROLLMENT FORM for RETIRED 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

Date of Retirement (mm/dd/yyyy)

II. Dependent/Type of Coverage Information

Your Spouse and Dependents are eligible to file claims of reimbursement under this Plan. 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.

I HEREBY AUTHORIZE MONTEBELLO TEACHERS ASSOCIATION RETIREE SUPPLEMENTAL HEALTH PLAN TO DEPOSIT A MONTHLY PREMIUM REIMBURSEMENT FOR MY MEDICARE HEALTH PREMIUM, DENTAL, AND VISION TO THE BANK ACCOUNT DESIGNATED ABOVE.

Check all that apply:

____ Health Premium ____ Dental ____ Vision

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 a "Covered Retiree" in this Plan, I must be a former employee who retired from the District under the California State Teachers Retirement System (CalSTRS) on or before June 30, 2025, and who, at the time of retirement from the District, was at least 55 years old and satisfied all of the eligibility requirements of Article 2, sections 1 and 2 of the January 2026 Summary Plan Description for Retired Employees. Additionally, I understand that if I return to employment with the District, in any capacity, it will disqualify me from being eligible for benefits and participation in this Retiree Plan. Instead, I will be able to obtain the remainder of your Allocated Amount under the Active Plan, upon satisfying the conditions of that Plan. A former employee who returns to employment with the District, in any capacity, is not a Covered Retiree while employed by the District.

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: _______________________

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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

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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