

**RTA CC EMPLOYEE BENEFIT PLAN TRUST
TECHNICAL CORRECTION #1**

**EFFECTIVE DATE AS OF FEBRUARY 1, 2000
REVISED EFFECTIVE DATE AS OF FEBRUARY 1, 2004
REVISED & RESTATED EFFECTIVE AS OF FEBRUARY 1, 2006
REVISED & RESTATED EFFECTIVE AS OF FEBRUARY 1, 2008
TECHNICAL CORRECTION EFFECTIVE DATE: FEBRUARY 1, 2008**

This Plan is changed to the following without altering any other provisions:

I. SUMMARY PLAN DESCRIPTION

Location: Medical Benefits, Organ Transplant Coverage, Page 34 - 36

Delete:

ORGAN TRANSPLANT COVERAGE

Subject to the provisions of the Schedule of Benefits and this section, benefits will be provided for treatment and care related to or required as a result of the transplant procedures outlined below.

- A. This Plan covers the following organ transplant procedures: (1) Renal, (2) Heart, (3) Heart/Lung, (4) Liver, (5) Bone Marrow, and (6) other organ transplant procedures which are determined to be effective procedures through peer review literature and case management policy at the time of the request for the procedure.
- B. In addition to the provision set out in Section A, benefits for tissue transplant procedures (autologous and allogeneic) will be governed by the current benefits provided by the Plan at the time the services were pre-certified. At the time this Plan was written, the following benefits were in effect:
- 1) Bone Marrow transplant (autologous and allogeneic) are limited as follow:
 - a) Prior approval for the bone marrow transplant must be obtained in writing.
 - b) Allogeneic bone marrow transplants or other forms of allogeneic stem cell rescue must meet the following requirements:
 - (1) At least five out of six major histocompatibility complex antigens match between the patient and the donor;
 - (1) The mixed leukocyte culture is non-reactive; and
 - (2) One of the following conditions is being treated:
 - a) Aplastic anemia;
 - b) Acute leukemia;
 - c) Hodgkin's lymphoma (Stage III A or IV B) and Stage IV intermediate or high grade lymphoma with bone marrow involvement;
 - d) Non-Hodgkin's Lymphoma (Stage III or IV A or B);
 - e) Severe combined immunodeficiency;
 - f) Wiskott-Aldrich syndrome;
 - g) Infantile malignant osteopetrosis;
 - h) Chronic myelogenous leukemia;
 - i) Chronic granulocytic leukemia;
 - j) Stage III or IV Neuroblastoma in children over 1 year of age; or
 - k) Homozygous beta-thalassemia (thalessemia major);
 - l) Myelodysplastic syndromes.

- C. All other uses of allogeneic bone marrow transplants or other forms of allogeneic stem cell rescue are not covered under this Plan. These transplants include, but are not limited to the following cases:
- 1) Cases in which four out of six or fewer major histocompatibility complex antigens match;
 - 2) Cases in which mixed leukocyte culture is reactive;
 - 3) Lymphoma patients incomplete remission;
 - 4) Polycythemia Vera;
 - 5) Small Lymphocytic Lymphoma;
 - 6) Intermediate or high-grade lymphoma other than Stage IV with bone marrow involvement and Hodgkin's lymphoma other than Stage IIIA or IVB;
 - 7) Multiple Myeloma;
 - 8) Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection; and
 - 9) Chronic Lymphocytic Leukemia, Ovarian Cancer, Solid Tumors.
- D. Autologous bone marrow transplants with or without autologous stem cell rescue are not covered under this Plan except for the following:
- 1) Stage III or IV Hodgkin's disease which has recurred after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement;
 - 2) Stage III or IV intermediate or high grade non-Hodgkin's lymphoma which has recurred after an initial complete remission, or is in first remission with poor prognostic factors with no bone marrow involvement;
 - 3) State III or IV Neuroblastoma without bone marrow involvement;
 - 4) Acute lymphocytic or non-lyphocytic leukemia which has recurred after an initial complete remission or is in first remission with poor prognostic factors; and Germ cell tumors with no prospect for a complete remission with standard dose therapy;
 - 5) Breast Cancer;
 - 6) Multiple Myeloma; and
 - 7) Ewing's Sarcoma (where tumor is metastatic or tumor is greater than 8 cm in size without metastases).
- E. Autologous bone marrow transplants or other forms of autologous stem cell rescue are not covered under this Plan. These bone marrow transplants include, but are not limited to the following:
- 1) Acute leukemia in first remission if poor prognostic factors are absent;
 - 2) Chronic lymphocytic and chronic myelogenous leukemia;
 - 3) Hodgkin's or non-Hdgkin's lymphoma in first remission if poor prognostic factors are absent;
 - 4) Intrinsic brain tumors;
 - 5) Ovarian cancer other than germ cell tumors;
 - 6) Lung cancer;
 - 7) Testicular cancer other than germ cell tumors
 - 8) Tumors of the gastrointestinal tract including those of the colon, rectum, pancreas, stomach, esophagus, gall bladder & bile duct;
 - 9) Wilm's tumor;
 - 10) Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection;
 - 11) Melanoma;
 - 12) Gastric Cancer;
 - 13) Tumors of the genitourinary system, including renal cell carcinoma and tumors of the cervix, uterus, fallopian tubes & prostate;
 - 14) Tumors of the head and neck, including nasopharyngeal tumors, thyroid tumors, paranasal sinus, neuro endocrine tumors & tumors of the unspecified history;
 - 15) Soft tissue sarcomas; and
 - 16) Tumors of unknown primary origin.

Benefits for autologous stem cell rescue when it is not accompanied by an autologous bone marrow transplant shall be reviewed on an individual basis through the Medical Management Program.

- F. Benefits as specified in the section will be provided for solid organ and tissue transplant living donor coverage. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
1. Donor coverage includes expenses for:
 - a) A search for matching tissue, bone marrow or organ.
 - b) Donor's transportation.
 - c) Charges for removal, withdrawal and preservation.
 - d) Donor's hospitalization.
 2. When only the recipient is a Covered Person, the donor is entitled to the benefits of this Plan which are not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any governmental program.
 3. When the donor is a Covered Person, the donor is entitled to the benefits of the Plan. No benefits will be provided to the non-covered transplant recipient.
 4. If any organ or tissue is sold rather than donated to the Covered recipient, no benefits will be payable for the purchase of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Covered Person's benefit Plan limit.

Replace With:

COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS

Pre-Authorization Requirement for Organ Transplant*

Expenses incurred in connection with any organ or tissue transplant listed in the provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. Transplant coverage is offered under this plan through a preferred provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his physician should contact the Plan Administrator for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the plan's medical review specialist.) Additional attending physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

*Failure to pre-authorize a transplant procedure will result in the application of a \$5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements, which would normally be applicable to the transplant procedure.

Organ Transplant Network

As a result of the pre-authorization review, the Covered Person will be asked to consider obtaining transplant services at a participating transplant center. The term “participating transplant center” means “a licensed healthcare facility which has entered into a participation agreement at fee arrangements as established with INTERLINK Health Services to provide health services to the Plan Sponsor.” The transplant network’s goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration of and enhancement of the quality of patient care.

There is no obligation for the patient to use network services. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of network, but the Covered Person has received approval for the plan’s medical review specialist for out of network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term “Transplant Benefit Period” means the period that begins on the date of the initial evaluation and ends on the date, which is twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

Covered Transplant Expenses

The term “covered expenses” with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as a covered only under this provision) and which are medically necessary and appropriate to the Transplant.

1. Charges incurred in the evaluation, screening, and candidacy determination process.
2. Charges incurred for organ transplantation.
3. Charges for organ procurement, including donor expenses not covered under the donor’s plan of benefits.
 - a) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.
 - b) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with the removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.
 - c) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient’s bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period).
4. Charges incurred for follow up care, including immune-suppressant therapy.
5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of \$10,000 per transplant period.

Re-Transplantation

Re-transplantation will be covered up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant and re-transplant will have a new benefit period and a new maximum benefit.

Accumulation of Expenses

Expenses incurred during any one transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the plan's overall per person maximum lifetime benefit.

Donor Expenses

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of \$10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Pre-Existing Conditions Limitation

Transplant charges will be subject to this plan's pre-existing conditions limitation.

Extended Benefits in the Event of Termination

In the event of termination of the plan, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are incurred during the lesser of: a) the remainder of that transplant benefit period or b) one month after termination of the plan or membership, as though coverage had not ended.

ORGAN TRANSPLANT SCHEDULE OF BENEFITS

Transplant Type	INTERLINK In-Network Benefits	INTERLINK Non-Network Benefits
Heart	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$110,000 including organ acquisition and physician's maximum of \$20,000.
Lung	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$155,000 including organ acquisition and physician's maximum of \$20,000.
Bone Marrow	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$130,000 including organ acquisition and physician's maximum of \$20,000.
Liver	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$130,000 including organ acquisition and physician's maximum of \$20,000.

Transplant Type	INTERLINK In-Network Benefits	INTERLINK Non-Network Benefits
Heart/Lung	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$150,000 including organ acquisition and physician's maximum of \$20,000.
Pancreas	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$70,000 including organ acquisition and physician's maximum of \$20,000.
Kidney	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$55,000 including organ acquisition and physician's maximum of \$20,000.
Kidney/Pancreas	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$90,000 including organ acquisition and physician's maximum of \$20,000.
Multivisceral/Small Bowel	100% of eligible charges	90% of eligible charges, up to an overall maximum of \$350,000 including organ acquisition and physician's maximum of \$20,000.

II. SUMMARY PLAN DESCRIPTION

Location: MEDICAL MANAGEMENT SERVICES-PRE CERTIFICATION/UTILIZATION REVIEW,
Page 53

Delete:

The patient, a family member or service provider must call this number to receive certification of certain Medical Management Services. This call must be made at least five (5) business days in advance of services being rendered or within two (2) business days after an emergency.

Replace With:

The patient, a family member or service provider must call this number to receive certification of certain Medical Management Services. This call must be made at least five (5) business days in advance of services being rendered or within two (2) business days after an emergency.

If you fail to use this utilization review program, benefits will be reduced by 50% for the hospital and ancillary charges. The 50% reduction will not apply to any out-of-pocket maximums.


Trustee Signature

03, 20, 08
Date

For Office Use Only
February 1, 2008
Technical Correction Effective Date

**REGIONAL TRANSPORTATION AUTHORITY
 ADMINISTRATIVE SERVICES AGREEMENT CONTRACT AMENDMENT # 5
 ORIGINAL CONTRACT EFFECTIVE DATE: FEBRUARY 1, 2000
 AMENDMENT EFFECTIVE DATE: FEBRUARY 1, 2009**

The Administrative Services Agreement Contract is amended to change the following without altering any other provisions:

I. ADMINISTRATION SERVICES AGREEMENT CONTRACT

Location:

Delete:

<u>Medical Plan Administration:</u>	Single Employee: \$7.00 per month	Employee/Family: \$14.00 per month
<u>Dental Plan Administration:</u>	Single Employee: \$2.00 per month	Employee/Family: \$4.00 per month
<u>Stop Loss Underwriting Fee:</u> <i>(Shown in Premium)</i>	Single Employee: \$7.00 per month	Employee/Family: \$14.00 per month
<u>Medical Helpline</u> <i>(Ask-A-Nurse/UR Management)</i>	Single Employee: \$3.50 per month	Employee/Family: \$7.00 per month
<u>COBRA / Medicare Part D:</u> <i>(Includes HIPAA)</i>	Single Employee: \$1.95	
<u>Transaction Fee:</u>	Per Transaction \$12.50	

Replace With:

Health Plan:	Single Employee: \$7.00	Employee/Family: \$ 14.00
Compliance Administration Fee: COBRA HIPAA, Medicare Part D & WHCRA Administration	Single Employee: \$1.95	Employee/Family: \$ 1.95
Underwriting Fee:	Single Employee: \$7.00	Employee/Family: \$ 14.00
Dental:	Single Employee: \$2.00	Employee/Family: \$ 4.00
Transaction Fee:	\$12.50	

II. ADMINISTRATION SERVICES AGREEMENT CONTRACT

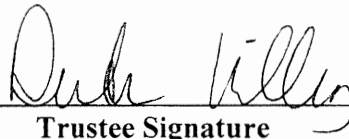
Location: SCHEDULE B – SCHEDULE OF EXPENSES & PROHIBITED TRANSACTION DISCLOSURE NOTICE

Delete:

HEALTH PLAN Vendor	Single Employee	Employee Family
Rx Card - TPAC	\$22.03	\$68.88
EAP/BH - CIGNA Behavioral Health	\$5.50	\$15.25
PPO/Repricing - SPOHN Health Network, Texas True Choice & Beechstreet	\$3.25	\$3.25

Replace With:

<i>SERVICES Payable Monthly Vendor</i>	<i>Single Employee</i>	<i>Employee Family</i>
Ask-A-Nurse/UR Medical Management Medical Helpline, Inc.	\$3.50	\$7.00
Generic Rx Capitated Program (GenX) TPAC Underwriters, Inc.	\$20.80	\$66.55
EAP/BH CIGNA Behavioral Health	\$5.10	\$15.00
PPO/Repricing SPOHN Health Network (Including \$1.25 Entrust Repricing Fee) & First Health	\$3.25	\$3.25
EXPENSES Payable as Incurred		
<i>Vendor</i>		
Transplant Network INTERLINK Health Service	Flat Access Fee per Occurrence or 25% of Savings for Non-Network Negotiation or other negotiation fees per separate agreement with vendor.	
Case Management Medical Helpline, Inc.	\$110.00 per hour or \$27.50 quarter hour	



Trustee Signature

2/23/09

Date

Reviewed By
Account Manager
For Office Use Only
February 1, 2009
Amendment Correction
Effective Date

RTACC EMPLOYEE BENEFIT PLAN TRUST
AMENDMENT #1
ORIGINAL PLAN EFFECTIVE DATE: FEBRUARY 1, 2008
AMENDMENT EFFECTIVE DATE: FEBRUARY 1, 2009

This Plan is changed to the following without altering any other provisions:

I. SUMMARY PLAN DESCRIPTION

Location: APPENDIX A - GENERAL PLAN INFORMATION

Delete: PREFERRED PROVIDER ORGANIZATION (PPO)



5000 Legacy Drive #190
Plano, TX 75024
Phone # (972) 739-6465
Fax # (972) 739-6614
www.texastruechoice.com



25500 Commercentre Drive
Lake Forest, CA 92630
Phone # (800) 877-1444
Fax # (949) 458-5337
www.beechstreet.com



CHRISTUS SPOHN
Health Network

P.O. Box 3947
Corpus Christi, TX 78463
Phone # 361-881-3280
or 800-419-3461
www.christusspohnhealthnetwork.org

Replace With: PREFERRED PROVIDER ORGANIZATION (PPO)



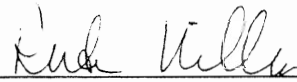
CHRISTUS SPOHN
Health Network

P.O. Box 3947
Corpus Christi, TX 78463
Phone # 361-881-3280
or 800-419-3461
www.christusspohnhealthnetwork.org



First Health Network

3200 Highland Avenue
Downers Grove, Illinois 60515
Tel. (800) 226-5116
www.myfirsthealth.com



Trustee Signature

2/23/09

Date

Reviewed By
<u>BH 2-10-2009</u>
Account Manager

For Office Use Only
February 1, 2009
Amendment Correction
Effective Date

**RTA CC EMPLOYEE BENEFIT PLAN TRUST
PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION**

ORIGINAL PLAN EFFECTIVE DATE: FEBRUARY 1, 2000

REVISED PLAN EFFECTIVE DATE: FEBRUARY 1, 2004

REVISED & RESTATED PLAN EFFECTIVE DATE: FEBRUARY 1, 2006

TECHNICAL CORRECTION #1 TO AMENDMENT #2 EFFECTIVE DATE: FEBRUARY 1, 2007

The Plan Document & Summary Plan Description is changed to the following without altering any other provisions:

I. Plan Document & Summary Plan Description

Delete:

Deductible Per Family Unit Per Calendar Month	\$500
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Replace With:

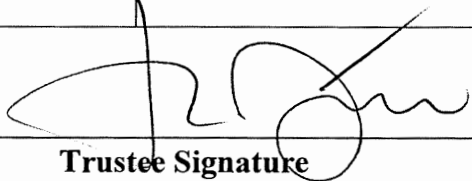
Deductible Per Family Unit Per Calendar Month (Maximum of \$2,000 per Single Coverage Maximum of \$4,000 per Family Coverage)	\$500
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Delete:

	Network Providers	Out of Network Providers
Hospital Service – Inpatient/Outpatient Daily Room and Board limited to the charges up to the semi-private room rate. Intensive Care Unit limited to the Hospital's ICU charge.	Deductible and coinsurance applies	Deductible and coinsurance applies

Replace With:

	Network Providers	Out of Network Providers
Hospital Service – Inpatient/Outpatient Daily Room and Board limited to the charges up to the semi-private room rate. Intensive Care Unit limited to the Hospital's ICU charge.	Deductible and coinsurance applies	\$250 Co-pay per Admission, then Deductible and coinsurance applies



Trustee Signature

Date

For Office Use Only
February 1, 2007
Technical Correction Effective Date

**REGIONAL TRANSPORTATION AUTHORITY EMPLOYEE BENEFIT PLAN
TECHNICAL CORRECTION # 2**

ORIGINAL PLAN EFFECTIVE DATE: FEBRUARY 1, 2008

TECHNICAL CORRECTION EFFECTIVE DATE: FEBRUARY 1, 2008

This Plan is changed to the following without altering any other provisions:

I. SUMMARY PLAN DESCRIPTION

Location: DISPOSITION OF TRUST FUND UPON ANY TERMINATION, PAGE 68

Delete:

DISPOSITION OF TRUST FUND UPON ANY TERMINATION

Upon termination of the Plan, the Trustee, in accordance with the Trust Agreement, shall apply all the remaining assets of the Trust Fund in a uniform and nondiscriminatory manner exclusively toward the provision of benefits and the administration of those there under for or on account of those persons enrolled in the Plan at the time of termination.

Replace With:

DISPOSITION OF PLAN ACCOUNT FUNDS UPON ANY TERMINATION

Upon termination of the Plan, the Named Plan Fiduciary shall apply all the remaining assets of the Plan Account Fund in a uniform and nondiscriminatory manner exclusively toward the provision of benefits and the administration of those there under for or on account of those persons enrolled in the Plan at the time of termination.

II. SUMMARY PLAN DESCRIPTION

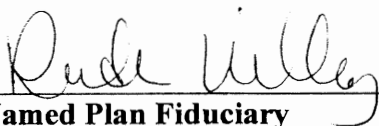
Location: APPENDIX A - GENERAL PLAN INFORMATION, PAGE 84

Delete:

TRUSTEE(S):	Mr. Ricardo Sanchez (Same address as Plan Sponsor)
NAMED FIDUCIARY:	Same as Above
AGENT FOR SERVICE OF LEGAL PROCESS:	See Trustee(s)

Replace With:

NAMED PLAN FIDUCIARY:	Ms. Ruth Willey (Same address as Plan Sponsor)
AGENT FOR SERVICE OF LEGAL PROCESS:	(See Named Plan Fiduciary)

 9/19/08

Named Plan Fiduciary Date

For Office Use Only
February 1, 2008 Technical Correction Effective Date