The following are summaries — please see plan brochures for details.

2021 — COMPARISON OF MEDICAL BENEFITS (PART TIME) — 2021

Benefit	Kaiser	UTU-MTA Self Funded Medical Plan PROVIDED BY TRUST FUND	UnitedHealthCare Value	UnitedHealthCare Harmony	Benefit
MAXIMUM BENEFIT	Full coverage at Kaiser facilities. No Maximum.	None. Covered expense under extended benefits is payable at 70% for all benefits during calendar year after satisfaction of the deductible.	Unlimited.	Unlimited.	MAXIMUM BENEFIT
DEDUCTIBLE	None.	$250.00 per calendar year.	None.	None.	DEDUCTIBLE
ELIGIBILITY	Member, Spouse and your children up to age 26. Children are your or your spouse's natural or adopted children, proposed adoptive children who are dependent on you pending finalization of the adoption, and children for whom you have been designated legal guardian by a court, and who are not eligible to receive group health benefits through their own employer. Foster children are not included. Proof of guardianship is required.	Employee only.	Member, Spouse and your children up to age 26. Children are your or your spouse's natural or adopted children, proposed adoptive children who are dependent on you pending finalization of the adoption, and children for whom you have been designated legal guardian by a court, and who are not eligible to receive group health benefits through their own employer. Foster children are not included. Proof of guardianship is required.	Member, Spouse and your children up to age 26. Children are your or your spouse's natural or adopted children, proposed adoptive children who are dependent on you pending finalization of the adoption, and children for whom you have been designated legal guardian by a court, and who are not eligible to receive group health benefits through their own employer. Foster children are not included. Proof of guardianship is required.	ELIGIBILITY
CHOICE OF DOCTOR AND HOSPITAL	Services provided only at Kaiser Facilities by Physicians affiliated with the plan.	You may select any licensed physician covered under the plan and any licensed hospital.	Services provided only by physicians and hospitals of Participating Medical Group chosen by member.	Services provided only by physicians and hospitals of Participating Medical Group chosen by member.	CHOICE OF DOCTOR AND HOSPITAL
HOSPITAL BENEFITS (IN-PATIENT)	$200.00 co-payment.	70% of contract rate for Prudent Buyer Network hospitals. 70% of usual, customary, and reasonable charges for non-contracting hospitals. Benefit limited to semi-private rooms up to 365 days per period of confinement/disability. Pre-authorization required.	$200.00 co-payment.	$200.00 co-payment.	HOSPITAL BENEFITS (IN-PATIENT)
URGENT CARE BENEFITS	$20.00 co-payment per office visit.	70% of contract rate for Prudent Buyer Network hospitals. 70% of usual, customary, and reasonable charges for non-contracting hospitals.	$20.00 co-payment per office visit in-network.	Provided at no charge in-network.	URGENT CARE BENEFITS
HOSPITAL BENEFITS (OUT-PATIENT SURGERY)	$20.00 co-payment per office visit.	70% of contract rate for Prudent Buyer Network hospitals. 70% of usual, customary, and reasonable charges for non-contracting hospitals.	Provided at no charge.	Provided at no charge.	HOSPITAL BENEFITS (OUT-PATIENT SURGERY)
PROFESSIONAL SERVICES FOR SURGERY, ANESTHESIA, DOCTORS VISIT IN HOSPITAL	Provided at no charge.	After $250.00 deductible is met, covered expenses payable at 70% of contract rate for Prudent Buyer Network provider. 70% plan allowance for non-contracting providers.	Provided at no charge.	Provided at no charge.	PROFESSIONAL SERVICES FOR SURGERY, ANESTHESIA, DOCTORS VISIT IN HOSPITAL
OFFICE VISITS AND INJECTIONS	$20.00 co-payment for each office visit. Most injectibles-including generally available immunizations, allergy test material, dressing and cast material–no charge.	See above for office visits. *Injections are provided by Accredo with a 20% copayment at (877) 222-7336. Medicines not covered by Accredo are referred back to the medical plan for review.	$20.00 co-payment for periodic health evaluations covered in full per office visit.	$20.00 co-payment for periodic health evaluations covered in full per office visit.	OFFICE VISITS AND INJECTIONS
X-RAYS AND LABORATORY TESTS	Provided at no charge.	See above.	Provided at no charge.	Provided at no charge.	X-RAYS AND LABORATORY TESTS
PHYSICAL THERAPY	$20.00 co-payment for each visit.	25 visit maximum per calendar year. Includes all therapies covered under the plan.	$20.00 co-payment per office visit.	$20.00 co-payment per office visit.	PHYSICAL THERAPY
AMBULANCE	$100.00 charge.	$2,000.00 maximum for ground ambulance transportation to a hospital for each illness or injury.	$100.00 charge.	$100.00 charge.	AMBULANCE
PRESCRIPTION DRUGS	Retail: $15 Generic, $30 Brand co-payment for up to a 30-day supply per prescription. Mail Order Incentive $30 Generic. $60 Brand co-payment for up to a 100-day suppy. Drugs for the treatment of Sexual Dysfunction and for Infertility covered at 50% of member rates.	**NOT COVERED.** Benefits are available through Express Scripts at (866) 312-7236. RETAIL: $5 generic, $10 brand name and $25 non-formulary. MAIL ORDER: one co-payment for a 90-day supply-$10 generic, $20 brand name and $40 non-formulary. Specialty drugs and injectables go through Accredo at (877) 222-7336 with a 20% co-payment. Medicines not covered by Accredo are referred back to the medical plan for review.	**NOT COVERED.** Benefits are available through Express Scripts at (866) 312-7236. RETAIL: $5 generic, $10 brand name and $25 non-formulary. MAIL ORDER: one co-payment for a 90-day supply-$10 generic, $20 brand name and $40 non-formulary. Specialty drugs and injectables go through Accredo at (877) 222-7336 with a 20% co-payment. Medicines not covered by Accreddo are referred back to the medical plan for review.	**NOT COVERED.** Benefits are available through Express Scripts at (866) 312-7236. RETAIL: $5 generic, $10 brand name and $25 non-formulary. MAIL ORDER: one co-payment for a 90-day supply-$10 generic, $20 brand name and $40 non-formulary. Specialty drugs and injectables go through Accredo at (877) 222-7336 with a 20% co-payment. Medicines not covered by Accreddo are referred back to the medical plan for review.	PRESCRIPTION DRUGS
ROUTINE PHYSICAL	No charge. One exam every12 months at no charge.	Covered at 100%. One exam every 12 months at no charge.	No charge. One exam every 12 months at no charge.	No charge. One exam every 12 months at no charge.	ROUTINE PHYSICAL
ROUTINE EYE EXAMINATION	No charge. Benefits also available through VSP at (800) 877-7195 or visit vsp.com (primary member only).	**NOT COVERED.** Benefits also available through VSP at (800) 877-7195 or visit vsp.com (primary member only).	Provided at no charge, one exam every 12 months. Benefits also available through VSP at (800) 877-7195 or visit vsp.com (primary member only).	Provided at no charge, one exam every 12 months. Benefits also available through VSP at (800) 877-7195 or visit vsp.com (primary member only).	ROUTINE EYE EXAMINATION
IMMUNIZATIONS	Provided at no charge.	**Part of routine care.**	Provided at no charge.	Provided at no charge.	IMMUNIZATIONS
MATERNITY CARE	Non-routine visits $20.00 co-payment. Inpatient $200.00 per admission. No charge for preventive prenatal and well-baby visits.	Benefits for normal delivery, Caesarean section and other complications of pregnancy at 70% of plan allowance for doctor care and other covered services.	Non-routine visits $20.00 co-payment. Inpatient $200.00 per admission. No charge for preventive prenatal and well-baby visits.	Non-routine visits $20.00 co-payment. Inpatient $200.00 per admission. No charge for preventive prenatal and well-baby visits.	MATERNITY CARE
MATERNITY WAITING PERIOD	**None.**	**None.**	**None.**	**None.**	MATERNITY WAITING PERIOD
PSYCHIATRIC CARE (MENTAL AND NERVOUS)	PSYCHIATRIC CARE: IN-HOSPITAL: Provided at $200.00 per admission; OUT-OF-HOSPITAL: Individual: $20 co-payment per visit / Group Therapy $10 co-payment per visit. Additional benefits are available through MHN at (800) 327-0449.	**NOT COVERED.** Benefits are available only through MHN at (800) 327-0449.	Inpatient Hospital: Provided at $200.00 per admission. Outpatient: $20.00 Co-payment per office visit.	Inpatient Hospital: Provided at $200.00 per admission. Outpatient: $20.00 Co-payment per office visit.	PSYCHIATRIC CARE (MENTAL AND NERVOUS)
EMERGENCY BENEFITS	$100 per visit. Emergency care (as defined in your Guidebook and Evidence of Coverage) is covered for Plan providers and non-Plan providers anywhere in the world. If you are admitted to a non-Plan hospital for an emergency condition, Kaiser Permanente must be notified within 24 hours or as soon as is reasonably possible by calling 1-800-255-8883.	Benefits are available throughout the world.	$100.00 co-payment for emergency services. Co-payment is waived if admitted. Services are available world-wide based on medical necessity.	$100.00 co-payment for emergency services. Co-payment is waived if admitted. Services are available world-wide based on medical necessity.	EMERGENCY BENEFITS
SPECIAL ACCIDENT BENEFIT	See emergency benefits above.	$300.00 - Accident benefit is provided for expenses incurred within 24 hours of the accident which occurs while you are eligible. Benefit must be used within 90 days of accident.	See emergency benefits above.	See emergency benefits above.	SPECIAL ACCIDENT BENEFIT
OPTIONAL DEPENDENT COVERAGE	Member may elect to cover one dependent for $71.00 per month or entire family for $130.00 per month. Payment will be due the 1st of each month. YOU WILL NOT BE BILLED. This election must be made when member first becomes eligible or dependent(s) is newly acquired.	**Not provided.**	Member may elect to cover one dependent for $71.00 per month or entire family for $130.00 per month. Payment will be due by the 1st of each month. YOU WILL NOT BE BILLED. This election must be made when member first becomes eligible or dependent(s) is newly acquired.	Member may elect to cover one dependent for $71.00 per month or entire family for $130.00 per month. Payment will be due by the 1st of each month. YOU WILL NOT BE BILLED. This election must be made when member first becomes eligible or dependent(s) is newly acquired.	OPTIONAL DEPENDENT COVERAGE

ADDITIONAL BENEFITS

Provided for members only.
Dependents are not eligible for these coverages.

GROUP LIFE INSURANCE

You will be insured for $2,500 of Life Insurance on the first day of the month following the completion of your probationary period at NO COST TO YOU! **(Primary member only)**

VISION CARE COVERAGE

Your eyes deserve the best care to keep them healthy year after year. With VSP you'll get the best value on your eye care and eyewear – including the option for contact lenses. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed – if you're not 100% happy, they'll make it right.

Using your VSP benefit is easy. To find a VSP doctor, visit vsp.com or 800-877-7195. Once you find a doctor you like, make an appointment directly with their office - there is no referral necessary. At your appointment, tell themyou have VSP. That's it - they handle the rest! There's no ID card necessary.

Benefits include an annual WellVision Exam® – the most thorough exam designed to detect conditions like diabetes, high blood pressure, and high cholesterol – along with other eye and health issues. Members also receive new lenses and frames once per calendar year. Contact lenses are available in lieu of glasses and are now available at the member's choice. A second pair of glasses per calendar year is available at a $50 co-pay. Please review the VSP plan summary for more detail or contact the Trust Fund for more information.

DENTAL SERVICE PLAN

Dental Health Services is available for your dental care. You may select a Dental facility from list of contracted participating dentist. Most dental services required are provided at **no cost** to you. The following services require a **co-payment** as shown:

	Amount You Pay
Office Visits	$5.00
Cleanings	.00
Scaling & root planing (deep cleaning)	.00
Irrigation (per quadrant)	$25.00
Restorations (fillings) Amalgam or Composite	.00
Porcelain Fused to High Metal Crowns	$220.00
Stainless Steel Crowns	$20.00
Root Canal Therapy (per tooth)	$20.00
Retreatment of root canal	$20.00
Bridge Units	$220.00
Partial Denture	$45.00
Full Denture	$45.00
Surgical Extractions	0.00

Additional co-payment may be required. Please review your Combined Evidence of Coverage & Disclosures or contact Dental Health Services for further details.

There is no coverage provided for orthodontia (straightening of the teeth.) Dependents are not covered under this program.

HEARING AID(S) COVERAGE

The Trust Fund allows for hearing aid(s) every **four years**, as long as the hearing loss is not work related. We require a copy of your hearing test and allow for $400.00 per aid.

ADDITIONAL INFORMATION ON HEALTH AND INSURANCE BENEFITS FOR YOU AND YOUR FAMILY

To ensure that you receive the benefits of your choice, you must make your selection by completing the necessary forms/documents and submitting them to the Trust Fund office during the Open Enrollment period.

DEADLINE for Open Enrollment Submissions: November 20, 2020.

If you are a new employee, you must submit your paperwork no later than 60 days from the date your enrollment becomes effective. Applicable contributions will still be due for any lapsed month(s). **Failure to submit the required documents, will result in enrollment under UTU-MTA self funded plan which provides lesser benefits. ONCE AN ENROLLMENT IS PROCESSED, IT CAN NOT BE CHANGED UNTIL THE NEXT OPEN ENROLLMENT PERIOD.**

Regardless of which plan you select, you must complete the Trust Fund enrollment card.

EMPLOYEE CONTRIBUTIONS

Monthly Contribution

Effective January 1, 2013, there will be a monthly contribution of $40.00 required from ALL Part Timers. This contribution will be deducted from your salary and/or wages.

DEPENDENT CONTRIBUTION for Kaiser, UnitedHealthCare Value & UnitedHealthCare Harmony

(UTU-MTA self funded does not provide dependent coverage)

Dependent coverage must be selected when member is first eligible or when dependents are first acquired. Enrollment documents and any payment(s) due must be received no later than 60 days from the qualifying event. Otherwise this option can only be selected during Open Enrollment. **You will be responsible for submitting your payment to the Trust Fund on the 1st of each month no later than the 15th of the month; (YOU WILL NOT BE BILLED).** Failure to pay as stated will result in termination of coverage for dependents. Once they are terminated, they are not eligible for re-enrollment until the next Open Enrollment period.

1 (one) dependent	**$71.00 per month__Method of payment: check or money order**
Family coverage (2 or more dependents)	**$130.00 per month__Payable: UTU-MTA Trust Fund.**

UTU-MTA TRUST FUND 2021

PART TIME OPERATORS

Dear Member:

Your Board of Trustees has over the years, worked diligently to provide the maximum possible medical, dental, vision care and life insurance benefits for you and your families. We believe the coverage's now in effect compare favorably with any group health program available today.

This pamphlet outlines the current benefits to be provided under each program in 2021. Please take a few minutes to read this pamphlet so you will be aware of the various coverage's available for your selection.

Please note that if you do not make a selection when you first become eligible, you will be assigned to the UTU-MTA self funded medical plan that provides lesser benefits. This plan does not allow dependent coverage. Once you are assigned to UTU-MTA self funded medical plan or enrolled in the plan of your choice, you will not be able to switch plans until the next Open Enrollment period.

Dependent Coverage:
If you enroll under the Kaiser, UnitedHealthCare Harmony or UnitedHealthCare Value plan and you wish to enroll your dependents, you must submit proof of dependency status within 60 days of when you first acquire them. Otherwise they will be unable to be enrolled until the following year's open enrollment. Examples of proof: marriage certificate, declaration of domestic partnership, birth certificate, verification of birth or adoption documents.

Dependent up to age 26: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in group health plan or health insurance coverage. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective January 1, 2021 (This only applies to medical, mental health and pharmaceuticals).

Incapacitated Children: Your children (regardless of age) who are unmarried and unable to do any work to support themselves because of mental or physical disability which started while eligible for coverage and which is certified by a physician. This must be certified by the Trust Fund prior to the dependent's 26th birthday.

Requirement: *As of 2012 medical providers are requiring social security numbers for all dependents. Should you fail to provide the Trust Fund with this information, the medical plan may terminate your dependent(s) coverage.*

Please submit any necessary documents to the Trust Fund office to ensure your enrollment change(s) are processed. Dependents cannot be enrolled without the required Social Security numbers, documents and/or payments. You must also complete and sign the enrollment card and proper application if you are changing your medical plan. *Your enrollment cannot be processed without complete paperwork.*

The Trustees and the Trust Fund will continue to work diligently to try to keep your costs as low as possible. We thank you in advance for your cooperation. If you have any questions concerning the benefits provided under these plans of your eligibility for benefits, please contact the Administrative Office of the Trust Fund, at (626) 962-1762 or (213) 624-6487.

Sincerely,

John M. Ellis
Chairman, Board of Trustees

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www.utu-mtatrustfund.com