Explanation

of

SMART-MTA Self Funded

Medical Plan

Hospital Medical Surgical

Benefits

Part Time 2022

SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART

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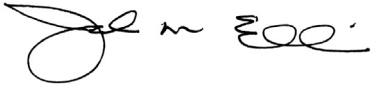
MESSAGE FROM THE CHAIRMAN, BOARD OF TRUSTEES

Dear Sisters and Brothers:

In order to give you a full explanation of the coverage and benefits available to you and your family, the Trust Fund has prepared this booklet, which hopefully will answer most of your questions.

We urge you to take the time to read this booklet, and keep it handy as a reference. Of course, if you have questions, don't hesitate to call the Trust Fund office.

Sincerely,



John M. Ellis
Chairman
Board of Trustees

FOREWORD

THIS BOOKLET explains your coverage and the benefits provided directly by the **Trust Fund**. In this booklet, "we", "us","our" and the "Plan" mean either Prudent Buyer Network or the SMART-MTA Trust Fund, as applicable. "You", "your" and "yours" refer to you the member.

We suggest you read this booklet carefully and then file it with your other important papers. You should know how to find out what benefits you can receive—and what you must do to receive them.

You must keep in mind that you have two different kinds of coverage: **hospital** and **medical**. The hospital benefits are provided through SMART-MTA Trust Fund and are priced through Prudent Buyer Network. This means that certain hospitals have agreed to accept a lesser amount. You may contact Anthem at 1-800-688-3828 or anthem.com/ca (if your out of state replace CA with your state abbreviation) to request a directory of these hospitals.

All in-state hospital and doctor bills should be sent directly to Anthem Blue Cross of California P.O. Box 60007, Los Angeles, CA 90060-0007. Out-of-state hospital and doctor bills should be sent to the local Anthem Blue Cross office.

The Trust Fund has also contracted with Anthem Blue Cross to provide the Prudent Buyer Network of providers which includes thousands of providers that can be found at anthem.com. These providers will be paid at a higher rate than non-participating providers. Using Prudent Buyer contracting providers will reduce your out-of-pocket expenses.

For that reason it is strongly suggested that you ask your physician if he or she is a Prudent Buyer Network provider before seeking treatment.

WHO IS COVERED AND HOW

You are covered if you meet one of the following criteria:

(a) You are a regular, part-time active employee of the Los Angeles County Metropolitan Transportation Authority, employed in a job classification covered by the contract between the Authority and the SMART Union, or are on authorized leave from such employment. New part-time em-ployees become eligible on the first of the month following 90 days of employment, except that persons transferred from part-time to full-time employment become eligible on the first day of the month next follow-ing the date of the transfer;

AND

(b) Required contribution(s) has been made.

WHEN COVERAGE ENDS

Coverage ends on the last day of the month in which your part-time employment with the MTA terminates, unless you become full-time.

CONTINUATION OF COVERAGE

If you cease to be eligible, you may continue coverage by payment of the required amount each month for up to the maximum amount of time and pursuant to the regulations implementing the Consolidated Ominibus Budget Reduction Act ("COBRA"). You will receive a notice regarding your COBRA rights and may contact the Administrative Office for further information.

YOUR BENEFITS

The two kinds of coverage — hospital and surgical-medical — work together to protect you when a medical problem arises. For example: If you're hospitalized, your hospital coverage provides benefits for room, board, general nursing care, and other hospital services including the charges made by hospital-based physicians such as a radiologist or path-

ologist; your surgical-medical benefits apply toward the cost of your physician's services.

HOW MUCH IS COVERED?
In some cases, such as most hospital care in a semi-private room, and depending on the contracting status of the provider, up to 70% of allowable charges will be covered. In other cases, you may only be eligible to receive benefits for a portion of your expenses. Some other expenses may not qualify for any benefits. The next sections of this booklet describe what the limits are and what conditions are covered for benefits. Later, under "Limitations and Exclusions", the treatments, services and expenses which are not covered are discussed.

PRE-ADMISSION AUTHORIZATION

Admission to hospitals requires prior approval in all cases except emergencies. Your doctor or hospital should call 1-800-274-7767 to obtain such approval, if you are out of the state of California please call 1-800-676-2583. In other areas the local review organization should be contacted. Pre-authorization does not guarantee benefits.

HOSPITAL BENEFITS

A "hospital" is a facility which provides diagnosis, treatment and care of persons who need acute in-patient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital under state and local laws, registered as a general hospital by the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals.

There are two classifications of hospitals which may be utilized. First, there is a participating hospital, which is a facility which has a Prudent Buyer Agreement with Anthem Blue Cross whereby the hospital agrees to a negotiated amount for allowed services and also agrees to a review of the charges, with services determined to be unnecessary after review not being covered. The other hospitals are called non-par-

ticipating and include those institutions which have not entered into such an agreement. Except in the cases of emergency care as more fully detailed below.

HOSPITAL IN-PATIENT CHARGES

In-patient services and supplies provided by a participating hospital, including Special Care Units, are **covered at 70% of the contracted rate (member is responsible for the remaining 30%). For non-participating hospitals, benefits are paid at 70% of allowed charges, except in case of emergency care, the allowed amount shall be no greater than the agreed rate by the participating hospital (member is responsible for the remaining balance) up to a maximum of 365 days per confinement**, except that:

(a) charges over the prevailing two-bed room rate are excluded;
(b) charges over the rate agreed to by participating hospitals are excluded;
(c) charges over what is determined as reasonable charges made by a non-participating hospital are excluded; and
(d) charges for services and supplies that are not medically necessary as defined are excluded. "Medically necessary" is defined as services and supplies determined to be:

    (1) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition (including the number of days of in-patient care to be provided).
    (2) Provided for the diagnosis or direct care and treatment of the medical condition.
    (3) Within standards of good medical practice within the organized medical community.
    (4) Not primarily for the convenience of the patient, a family member, the physician, or another provider.
    (5) The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an in-patient is necessary due to the kind of service you are receiving or the severity of the condi-

tion, and safe and adequate care cannot be received as an out-patient or in a less intensified medical setting. The Trust Fund will not pay benefits for care on a day when, in our judgment, acute hospital care was not necessary.

The benefits described above are also provided in connection with pregnancy for female member only.

The above benefits are also provided for care received in an approved skilled nursing facility if you are referred to such a facility by a physician (M.D. or D.O.) and remain under the active medical care of a physician while so confined.

The Trustees of the Trust Fund shall have sole and final discretion in determining what services and supplies are covered under the plan.

EMERGENCY HOSPITAL IN-PATIENT OR OUT-PATIENT

Participating emergency room hospital in-patient or out-patient services are paid at 70% (member is responsible for the remaining 30%). For non-participating hospitals, benefits are paid at 70% of allowed charges, and the member is responsible for the balance.

HOSPITAL OUT-PATIENT CHARGES

The services covered are the same as those covered for in-patient services. They are covered (when provided) for the following conditions, when the care is received in the emergency room or operating room of a hospital.

(a) ***FOR SUDDEN AND SERIOUS ILLNESS***, you can get out-patient benefits for your hospital visit but it is treated as if such care were received in a physician's office, with the deductible under the surgical-medical benefits being applied and payment based on the benefits provided under that coverage. These benefits are paid directly by the Trust Fund.

(b) ***FOR AN ACCIDENTAL INJURY***, you can get out-patient benefits for your first visit to

the hospital but it must be within 24 hours of the accident. Otherwise it will be handled the same as (a) above. Follow up visits are not covered except as in (a) above.

(c) ***FOR SURGERY***. Surgery includes such items as closed reduction of fractures, dislocations of bones and other procedures which require the use of the surgical facilities of the hospital.

(d) ***AMBULANCE CHARGES***. The charges for services by a licensed ambulance company for ground ambulance transportation to a hospital will be paid up to a **maximum of $2,000.00** per trip. The member is responsible for the balance.Transportation from facility to facility is not covered. To qualify, you must be either admitted as an in-patient or receive emergency out-patient care. Services include the base charge, mileage, non-reusable supplies, and charges for monitoring, administration of oxygen and intravenous solutions administered in connection with the ambulance service.

BENEFITS FOR SERVICES PROVIDED BY OTHER THAN HOSPITALS

(THESE BENEFITS ARE PROVIDED BY THE TRUST FUND ON A DIRECT-PAY BASIS.)

This covers services by individual practitioners —not by hospitals.

Who are practitioners? They are:

(1) A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), who is licensed to practice medicine or osteopathy where the care is provided.

(2) One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are provided, and when benefits would be payable if the services were performed by an M.D. or D.O.:

a. A dentist (D.D.S.)
b. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
c. A chiropractor (D.C.)
d. A physical therapist (P.T. or R.P.T.)*
e. A speech pathologist*
f. An audiologist*
g. An occupational therapist (O.T.R.)*

NOTE: The providers indicated by asterisks (*) are covered only when referral is made by an M.D. or D.O.

MEDICAL-SURGICAL BENEFITS

If you use Prudent Buyer Network physician you are still liable for the annual deductible.

Non-Emergency Medical-surgical benefits are paid as follows:

a. Participating providers are paid 70% of the Prudent Buyer Network negotiated rate. The member is responsible for the remaining 30%.

b. Non-participating providers are paid 70% of plan allowance. Allowance is based on usual and customary charges. The member is responsible for the balance.

HOW MUCH WILL YOU RECEIVE

Annual Deductible Amount.

The plan imposes an annual deductible on medical-surgical charges before benefits are payable. The annual deductible is $250. This deductible is applied to the charges submitted each year in the order in which the billings are received.

If you pay the provider directly and the amount you pay is not reflected in charges submitted for payment, the amount will not be recognized and the deductible will be applied only against charges actually received. Expenses incurred in the last quarter of any calendar year and applied to the deductible for that year will be carried forward and applied to the deductible for the next calendar year also.

WHAT SERVICES ARE COVERED

The following are among the different kinds of services for which allowances are provided.

SURGICAL SERVICES. Surgical service includes cutting or other non-invasive techniques to cure or relieve the effect of illness or injury. This includes closed reduction of fractures, dislocation of bones and endoscopies as well as incisions or punctures of the skin or other tissue, except for, collection of blood, drug administration or injection. Charges for routine care related to surgery are included as part of your surgical benefit. All follow-up care should be included in the surgical allowance unless other wise stated.

SURGICAL CENTERS Non-contracting surgical centers will be paid at $2,000.00 maximum, for any and all services provided and charges incurred.

ANESTHESIA SERVICE. To be a covered benefit, general anesthesia service must be provided by an anesthesiologist as part of a covered surgical or maternity service.

Pain management epidural(s) is not a covered benefit.

ASSISTANT SURGEON. *A* physician to help your surgeon. These benefits are provided only if your operation is one which requires the help of a surgical assistant.

MATERNITY CARE. Care for childbirth and for any other condition related to pregnancy. This benefit is provided for female members only.

MEDICAL VISITS. *Medical visit(s) is a* non-surgical treatment by your physician while you are an in-patient in a hospital or at the physician's office. As noted before, when you have surgical or maternity service, the allowance paid for them includes related non-surgical services and, therefore, additional payments are not made for these non-surgical services.

DIAGNOSTIC X-RAY AND LABORATORY. X-rays and laboratory tests ordered by your doctor and necessary for the diagnosis or treatment of a covered injury or illness. Not all tests, examinations or x-rays requested by a practitioner are covered.

ADDITIONAL SERVICES AND SUPPLIES. Expenses for the following items are covered when necessary for the treatment of an illness or injury:

(a) Radiation therapy, chemotherapy and hemodialysis treatment.
(b) Blood transfusions, including blood processing and cost of unreplaced blood and blood products.

The following items are also covered as follows:

Contracting	**70% of allowable charges (member is responsible for 30%)**
Non-contracting	**70% of allowable. Member is responsible for balance.**

(a) Surgical implants and artificial limbs or eyes.

(b) Private duty services of a Registered Nurse (L.V.N. or R.N.), when certified as necessary by the practitioner.

(c) Rental or purchase of other medical equipment and supplies which are: (1) ordered by a physician, (2) of no further use when medical need ends, (3) usable only by the patient, (4) not primarily for the member's comfort or hygiene, (5) not for exercise, and (6) made specifically for medical use. This benefit will be paid at 80% of allowable charges for contracting providers and 80% of the plan's allowance for non-contracting providers, up to purchase price.

PREVENTATIVE CARE AND IMMUNIZATIONS

All preventative services with a "Grade" A or B as determined by the U.S. Preventative Services Task Force:

(a) routine vaccines
(b) preventative care for women covered at 100%

(c) 1 routine adult physical exam every 12 months

For a detailed list please visit:
http://www.healthcare.gov/preventive-care-adults
http://www.healthcare.gov/preventive-care-women

SUPPLEMENTAL ACCIDENT BENEFIT

$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.

FILING YOUR CLAIM

If you receive treatment that is covered under the program, we will do our best to pay benefits promptly. To do this, we need the following from you and your practitioner:

(1) A completed claim form, either on our form or another form which includes the same information as our form. If we do not receive the form, we will not be able to provide benefits. However, benefits shall not be allowed if notice of claim is made beyond one year from the date on which such expenses were incurred. The form should be sent to: Anthem Blue Cross P.O. Box 60007, Los Angeles, CA 90060-0007

(2) More data from you or your practitioner, if requested. We may need written statements about the services you received—information such as itemized bills; details of the treatment or other service you received; other coverage you may have; whether the injury or illness was work-related; details concerning injuries caused by a third party; etc.

Failure to submit requested information will result in delay or denial of benefits. Payments will be made to you unless you have assigned the benefits to the practitioner. In either event, an explanation of the benefits paid will be sent to you. This explanation will show the name of the practitioner, the date of service for which payment is

being made, the charges, exclusions from payment and the amount of the payment. This form may also include comments to advise of other information about the payment made or the reason payment was not made.

APPEALING YOUR CLAIM

If you have any questions about the processing of, or decision concerning your claim, you should contact the Trust Fund Office at (626) 962-1762 or (213) 624-6487.

If you wish to appeal the Plan's decision you must address your appeal to:

SMART-MTA Trust Fund
Attention: Appeals
15999 Cypress Avenue
Irwindale, CA 91706

Should you disagree with our claim determinate, an appeal may be submitted. All appeals are to be submitted in writing and state, in clear and concise terms, the reason for the disagreement with the decision. The appeal is to include any information or documentation that was not presented with the original claim.

The failure to file an appeal within 60 days from the receipt of the initial adverse decision shall constitute a waiver of the right to request a review of the decision. Thereby, leaving the decision as final and binding. Such failure will not, however, prevent an applicant from establishing future review entitlement based on additional information and evidence which was not available at the time the decision denying the claim(s), in whole or in part, was made.

If an appeal is denied due to a lack of medical necessity, the claim for benefits may be eligible for an external review by an independent third-party review organization. Appeals seeking independent third-party review must be submitted within four months of an appeal's denial.

LIMITATIONS AND EXCLUSIONS

This portion sets forth certain items which are not covered. We suggest you check this section before you file for benefits. It could save you the time and trouble of sending us a claim for services the plan does not cover. The following conditions and exclusions are in addition to any discussed elsewhere:

1. These facilities do not meet the definition of a hospital: convalescent homes and institutions: institutions primarily for the rest of the aged: spas; sanitariums; infirmaries at schools, colleges, or camps; and any institution primarily for treating drug addiction, alcoholism or mental disorders.

2. Services and supplies that are not medically necessary.

3. Nurse practitioners, CRNA's, physician's assistance (PA's), etc.

4. Expenses in excess of the rate negotiated with a Participating Hospital, or in excess of the customary and usual charge.

5. Services for which you are not legally obligated to pay, or services for which you are not charged or would not be charged if you did not have this coverage.

6. Work-related conditions even if you do not claim Workers' Compensation benefits.

7. Conditions caused by an act of war or by release of nuclear energy, whether or not the result of war.

8. Services for which payment may be obtained from any local, state, or federal government agency (except Medi-Cal). The benefits of this plan will be paid first if you are in active employment and either you or your eligible dependent are entitled to Federal Medicare benefits. If you are 65 or older, then the benefits of this plan will be available after the Federal Medicare benefits have been paid.

9. Services received from a person who lives in your home or is related to you by blood or

marriage.

10. Charges for in-patient care in connection with a hospital stay primarily for physical therapy or treatment of chronic pain or for diagnostic tests which could have been performed safely on an out-patient basis.
11. Services for care or treatment of mental, nervous or eating disorders. Coverage of these conditions is provided only through MHN. They can be reached at (800) 327-0449 or visit https://www.mhn.com/.
12. Services for care or treatment of alcoholism, drug addiction or substance abuse. Coverage of these conditions is provided only through MHN. They can be reached at (800) 327-0449 or visit https://www.mhn.com/.
13. Services relating to treatment on or to the teeth or gums, except in cases of accidental injury to natural teeth.
14. Charges for, or incidental to, the treatment of Temporomandibular Joint Syndrome.
15. Charges for hearing aids and routine hearing tests. Benefits for hearing appliances are provided under a separate program. Contact the Trust Fund for details.
16. Optometric services, eye exercises including orthoptics, routine eye examinations, routine eye refractions, eyeglasses, contact lenses, any surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism. Certain benefits are provided under a separate vision care program. Contact the Trust Fund for details.
17. Prescription drugs. Coverage is provided by Express Scripts, and can be reached at (866) 312-7273.
18. Injectable and specialty drugs are no longer covered under this plan, Before having services rendered please contact Accredo to see if medications are covered by them. You may contact Accredo for coverage information at (877) 222-7336. Medicines not covered by Accredo are referred back to the medical plan for review.
19. Charges for acupuncture or biofeedback.

20. Charges for cosmetic surgery or other services for beautification, anti aging or other cosmetic purposes, except as a result of accidental injury, provided the surgery is performed within 90 days of the accident.
21. Treatment of complications from prior cosmetic surgery or complications from other beautification, anti aging or other cosmetic services, unless the treatment occurs one year after the initial cosmetic surgery or service, is determined to be medically necessary, and does not have a cosmetic purpose. Pre-authorization is required for any medically necessary treatment of complications from prior cosmetic surgery or service. At the discretion of the Plan, the Plan may require a confirming Independent Medical Examination (IME) opinion by a physician selected and paid for by the Plan to verify medical necessity.
22. Services for the purpose of weight reduction or treatment of obesity and/or complications from obesity. This includes, but is not limited to, bariatric surgery, gastric restrictive procedure, gastric bypass and gastroplasty.
23. Treatment of complication from prior weight reduction surgeries. This includes, but is not limited to, bariatric surgery, gastric restrictive procedure, gastric bypass and gastroplasty.
24. In vitro fertilization or sterilization reversals.
25. Charges for nutritional counseling or doctor home visits.
26. Orthopedic shoes, foot orthotics or shoe inserts. Charges for the diagnosis and fitting of orthotics also are not covered.
27. Covered medical charges for the following therapies will be limited to a maximum total of 25 such treatments rendered on an outpatient basis during a calendar year: Physical therapy, Speech therapy, Occupational therapy, Rehabilitation therapy, Respiratory therapy, therapy that involves manual manipulation of the musculo-skeletal system, including chiropractic care.

28. Experimental or investigative therapy, including any type of therapy not generally recognized as of value by the medical community and its societies, is not covered. All other charges, as for office visits or laboratory procedures, incurred in conjunction with non-covered therapy will be considered not-covered.
29. Custodial or Domiciliary Care.
30. Any illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party. Benefits will be advanced in these instances subject to the following:
    (a) We will automatically have a lien, to the extent benefits are advanced, upon any recovery, whether by settlement, judgement or otherwise that you receive from the third party, the third party's insurer, or the third party's guarantor.
    (b) You agree to advise us, in writing, within 60 days of your claim against the third party and further agree to take such action, furnish such information and assistance, and sign such papers as may be required to allow us to exercise our right to recovery. You must further agree to do nothing which may prejudice our rights or interest. If you do not comply with these requirements, you will be held personally responsible for reimbursing us to the extent of benefits paid. This may be accomplished by the withholding of benefits otherwise payable on future expenses until the sums are recovered.
31. Any condition resulting from an intentionally self-inflicted injury.
32. Tax liens, interest payment, no shows and late fees.
33. Neuromuscular Stimulator Interferential, Tens unit, Electrical Nerve Stimulator are not covered. All Durable Medical Equipment are subject to review. Large items will be allowed if authorized one per lifetime; maintenence covered only.

34. Tattoo Removal.

35. Epidural(s) used for pain management.

The Trust Fund Trustees have the sole discretion to interpret the terms and coverage of the Plan, excluding services and any other Plan Provisions in determining whether a service or treatment is covered.

COORDINATION OF BENEFITS

It is not unusual to find yourself covered by two health insurance policies providing similar benefits, both issued to or through groups. When that is the case and you receive an item of service which would be covered under either plan, we will coordinate benefits with the other program. One plan will pay its full benefit as a primary benefit. The other will pay secondary benefits if necessary to cover your expenses. This prevents duplicate payments and overpayments.

In order to determine which plan is primary, certain rules have been established as follows:

1. If the other plan does not have a provision similar to this one, then it will be primary.
2. If you, the person receiving the benefit, are the member belonging to the group and you are only covered as a dependent on the other plan, the plan under which you are the member will be primary.
3. If none of the above applies, then the plan which has covered you for the longest time will be primary.

The above rules apply whether or not you actually make a claim under both plans.

If we pay more than we should have under this provision, we have the right to recover the excess from you or any other person, insurance company or organization which may have gained from our overpayment. You agree to do whatever is necessary to help us in recovering our excess payment—for example, completing and filing claim forms and endorsing checks over to us.

MEDICARE ELIGIBLES

If you are an active employee and eligible for Medicare, this Plan will be primary.

– Disclaimer –

The Plan is operated under the provisions of an Agreement and Declaration of Trust, and all benefits provided are subject to the terms of the Trust, and the Group Master Contracts issued by the following insurers: Anthem Blue Cross. The terms of these documents will prevail in the interpretation of questions concerning any subject matter covered in this Summary Plan Description.

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Trustees of the Plans. The Trustees shall also have full discretion and authority to interpret the Plan of Benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretation or opinions given by employees of the Plans are not binding upon the Trustees and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Trustees reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time.

SMART-MTA TRUST FUND
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