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

2023 — COMPARISON OF MEDICAL BENEFITS (FULL TIME OPERATORS) — 2023

Annual MAXIMUM BENEFIT	Kaiser Unlimited	SMART-MTA Self Funded Medical Plan PROVIDED BY TRUST FUND Unlimited	UnitedHealthCare Value Unlimited.	UnitedHealthCare Harmony Unlimited.	Annual MAXIMUM BENEFIT
DEDUCTIBLE	None.	$250 per calendar year per person. After 2 persons have satisfied a $500 family deductible each, the family deductible will be considered satisfied. There is a $5,000.00 annual out of pocket loss for this plan.	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.	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.	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 subscriber or eligible dependent.	Services provided only by physicians and hospitals of Participating Medical Group chosen by subscriber or eligible dependent.	CHOICE OF DOCTOR AND HOSPITAL
HOSPITAL BENEFITS (IN-PATIENT)	$200.00 co-payment.	80% of contract rate for Prudent Buyer Network hospitals. 60% of usual, customary, and reasonable charges for non-contracting hospitals. Benefit limited to semi-private room 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.	80% of contract rate for Prudent Buyer Network hospitals. 80% 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) (OUT-PATIENT SURGERY)	$20.00 co-payment.	80% of contract rate for Prudent Buyer Network hospitals. 60% of usual, customary, and reasonable charges for non-contracting hospitals.	Provided at no charge.	Provided at no charge.	HOSPITAL BENEFITS (OUT-PATIENT) (OUT-PATIENT SURGERY)
PROFESSIONAL SERVICES FOR SURGERY, ANESTHESIA, DOCTORS VISIT IN HOSPITAL	Full coverage at Kaiser facilities. No Maximum.	After $250.00 deductible, covered expenses are payable at 80% of contracted rate for Prudent Buyer Network providers. 60% of plan allowance for non-contracting providers.	No charge.	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.	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.	No charge.	No charge.	X-RAYS AND LABORATORY TESTS
PHYSICAL THERAPY	$20.00 co-payment per 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
CHIROPRACTIC CARE	Provided through panel at charge of $10.00 per visit. Maximum of 20 visits per year.	Provided same as physicians but limited to physical therapy a maximum of 25 visits per year (included in above maximum). Non-panel providers paid at scheduled allowance.	$10.00 co-payment per visit. Up to 20 visits per calendar year.	$10.00 co-payment per visit. Up to 20 visits per calendar year.	CHIROPRACTIC CARE
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:** $15.00 Generic $30.00 Brand co-payment **Mail Order:** $30.00 Generic and Brand $60.00 for up to a 100-day supply. Drugs for the treatment of Sexual Dysfunction and for Infertility covered at 50% of member rates.	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.	**Retail:** 30-day supply $15 Generic $30 Brand $50 non-formulary. **Mail Order:** Two co-payments for up to a 90-day supply.	**Retail:** 30-day supply $15 Generic $30 Brand $50 non-formulary. **Mail Order:** Two co-payments for up to a 90-day supply.	PRESCRIPTION DRUGS
ROUTINE PHYSICAL	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	Benefits also available through VSP at (800) 877-7195 or visit vsp.com.	Provided at no charge, one exam every 12 months. Benefits also available through VSP at (800) 877-7195 or visit vsp.com.	Provided at no charge, one exam every 12 months. Benefits also available through VSP at (800) 877-7195 or visit vsp.com.	ROUTINE EYE EXAMINATION
IMMUNIZATIONS	Provided at no charge.	**Part of routine care.**	Specified Immunizations: No charge.	Specified Immunizations: No charge.	IMMUNIZATIONS
PREGNANCY CARE	Non-routine visits $20.00 co-payment. Inpatient $200.00 per admission. No charge for preventive prenatal and well-baby visits.	**MEMBER AND SPOUSE ONLY.** All basic hospital benefits for normal delivery, Caesarean section and other complications of pregnancy. Payable at same rates as professional 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.	PREGNANCY 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: $20.00 co-payment per visit/ Group Therapy $10.00 co-payment per visit. Additional benefits available through MHN at (800) 327-0449.	Benefits 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	$100.00 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-Accident benefit is provided for expenses incurred within 24 hours of the accident which occures while you are eligible. Benefit must be used within 90 days of accident.	See emergency benefits above.	See emergency benefits above.	SPECIAL ACCIDENT BENEFIT

COMPARISON OF DENTAL BENEFITS

DENTAL HEALTH SERVICES

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	$20.00
Bridge Units	$220.00
Partial Denture	$45.00
Full Denture	$45.00
Surgical Extractions	.00

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

Orthodontic care (straightening of teeth) is provided for children (of full-time employees) between the ages of 10 and 19, subject to certain provisions for qualification. Please contact Dental Health Services for details and treatment referral.

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 them you 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.

DELTA DENTAL

The Delta Dental PPO program allows you the freedom to visit any licensed dentist. However, you will usually have the *highest* level of coverage and pay the *lowest* amount for services when you visit a Delta Dental PPO dentist. There are more than 18,000 PPO dentists to select from in California. Delta Dental Premier Dentists who do not participate in the PPO network are classified as *Out-of Network*.

Annual deductible and benefit maximum apply each calendar year.

Deductibles:	In-Network	$25 per person,	$75 per family
	Out-of-Network	$100 per person,	$300 per family
Maximum:	In-Network	$1,500 per person	
	Out-of-Network	$500 per person	

Total combined *In* and *Out-of-Network* benefits are not to exceed $1,500 in a calendar year. If you have already exceeded $500 in *In-Network* benefits you will not be eligible for *Out-of-Network* benefits as you have already exceeded the $500 maximum benefit for the year.

- Diagnostic & Preventive services *In-Network* 100% and 50% *Out-of-Network*.
- Restorative services are covered at 50%
- Major corrective services are covered at 50% *In-Network*, 40% *Out of Network*,
- Orthodontia for children is covered at 50%, no deductible (lifetime maximum of $1,500 *In-Network* and $1,000 *Out-of-Network* per child)

Out-of Network reimbursement is paid on Delta's PPO allowance and not necessarily each dentist's actual fee. To avoid balance billing it's recommended that you seek services from a Delta Dental PPO dentist.

If you want vision for your children age(s) 19 up to 23 you must submit proof of full time student status (12 or more credits) this must be submitted every semester/quarter.

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.

GUIDELINES ON HOW TO SECURE THE BEST HEALTH AND INSURANCE BENEFITS FOR YOUR FAMILY

Read the comparisons thoroughly before you make a selection.

To ensure that you receive the benefits of the plan(s) of your choice, you must make your selection by filling out the necessary forms/documents and returning them to the Trust Fund Office during the Open Enrollment period (no later than November 19, 2021). If you are a new employee, you should submit your enrollment documents at least five days prior to your enrollment becoming effective to avoid denial of benefits.

DEADLINE for Open Enrollment Submissions: November 30, 2022.

Regardless of which plan(s) you select, you must complete the Trust Fund Enrollment Card and submit the required documents. IN ADDITION, you must complete the enrollment form required by the plan(s) if you select Kaiser, UnitedHealthCare Harmony, UnitedHealthCare Value, Delta Dental or Dental Health Services. **ONCE YOU ARE ENROLLED OR ASSIGNED TO A PLAN, YOU CAN NOT CHANGE YOUR SELECTION UNTIL THE NEXT OPEN ENROLLMENT PERIOD.**

EMPLOYEE MONTHY CONTRIBUTIONS

Full Time Members: Effective January 1, 2013, there will be a monthly contribution of $100.00 required from all Full Time members. This contribution will be deducted from your salary and/or wages.

Retired Members: Effective January 1, 2013, there will be a monthly contribution of $100.00 required from all Retired members. Full Time employees who were hired on or after September 7, 1991, and who retire with 23 years or more of service will have to contact the Trust Fund to get details on monthly contribution(s). Payment is due the 1st of each month, YOU WILL NOT BE BILLED. **If your payment is not received on time your benefits will be terminated.**

Dependent Coverage: Dependent coverage is available for no additional charge for all medical plans.

GROUP LIFE INSURANCE

In addition to the above mentioned medical benefits, you and your eligible enrolled dependents will be insured for Life Insurance benefits. Coverage will become effective on the first (1st) of the month following sixty (60) days of full-time employment at NO COST TO YOU.

Coverage amounts: Employee $4,000.00 Spouse $1,500.00
Children: Age 6 months up to 23 years $1,500.00. Age 14 days to 6 months $100.00.

You may elect to take advantage of the opportunity to purchase additional life insurance for yourself in increments of $5,000 up to $250,000, for your spouse in increments of $5,000 up to $100,000, and for your children for $10,000. If not enrolled when first eligible, enrollment can only occur thereafter during Open Enrollment. The rates are determined by your age. If you are an active employee, the payment will be deducted from your salary and/or wages. Retirees are responsible for making their payments to the Trust Fund, **YOU WILL NOT BE BILLED.** Your payment is due no later than the 1st of each month. Failure to make the payment will result in termination of this benefit. Please note that based on the benefits selected you may be required to show proof of insurability.

MOVING OUTSIDE OF SERVICE AREA OR OUT OF STATE.

If you are moving out of the service area of your current plan or out of California, be advised that your benefit ***options are limited***. You must contact the Trust Fund office in order to obtain details. Failure to do so may result in denial of benefits. Once your benefits are changed because you moved out of the area, they can only be changed back during the next Open Enrollment period.

SMART-MTA TRUST FUND 2023

FULL 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 coverages 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 2023. Please take a few minutes to read this pamphlet so you will be aware of the various coverages available for your selection.

Dependent Coverage:

If 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 enrolled the first of the month following receipt of your enrollment request.

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, 2023 (This only applies to dental, 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 and documents. You must also complete and sign the enrollment card and proper application if you are changing your medical or dental 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 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

Eddie Gonzalez
Administrator

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