HEALTH AND WELFARE PLANS FOR ACTIVE AND CASUAL EMPLOYEES

benefit booklet and summary plan description

EFFECTIVE AUGUST 1, 2009
(INCLUDES BENEFIT CHANGES THROUGH AUGUST 1, 2009)
Dear Active and Casual Employees and Family Members:

This Booklet describes the plans offered to active and casual employees by the Western Teamsters Welfare Trust (the Trust). It contains the eligibility rules for the benefit options, the continuation options available through COBRA, the claims and appeal procedures used by the Trust and other information. It also includes the Summary Plan Description information required by the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits available through the Trust are funded by employer contributions as reflected in certain collective bargaining agreements including those negotiated by your Teamsters local union and your employer. The negotiated contributions are paid into the Trust which then provides your benefits. The Trust is managed by a joint labor-management Board of Trustees whose services are voluntary and without compensation from the Trust. The Board of Trustees designs and administers the benefit programs.

The Trust provides a comprehensive set of benefits. We encourage you to become familiar with your benefits and the valuable protection they offer you and your family.

The rules governing the plans are extensive and are explained in detail in the following pages. We urge you and your family to read this booklet carefully to become familiar with your benefit entitlements and how to obtain them.

The Trustees believe that the terms of the Plan fully comply with ERISA and all other applicable laws and regulations, and amendments thereto. The Plan will be administered in accordance with these laws and regulations.

The Trustees provide benefits to the extent that monies are currently available to pay the costs of these benefits. Benefits are not guaranteed to continue indefinitely. Pursuant to the terms of the underlying Trust Agreement, the Trustees are vested with the authority to determine the benefits to be provided and the conditions of eligibility, and to make such changes, on the basis of actuarial principles, as they may determine including, if necessary, termination of the Trust.

If you would like further information or assistance, please call or write your Area Administrative Office. You will find a list of the Area Administrative Offices and telephone numbers on page 118.

Sincerely,

Board of Trustees Western Teamsters Welfare Trust

Employer Trustees
Jim Roberts, Co-Chair
John Coulson
A.J. Phillips
William R. Davidson

Union Trustees
Joe Silva, Co-Chair
Randy Cammack
Justin “Buck” Holliday
Jim Santangelo
Walter Maestas
Address Questions to Area Offices

All questions about Plan participation, eligibility for benefits, and the nature and amount of benefits, should be referred to your Area Administrative Offices. Only the Board of Trustees, the Principal Trust Office, and the Area Administrative Offices are authorized to answer questions concerning the Trust and its benefit plans. No participating employer, employer association, labor organization, or any individual employed thereby has any authority to give plan information.

Future Amendments

This Plan Booklet and Summary Plan Description is complete and up-to-date as of September 1, 2009. Future amendments will be published in the form of inserts which you should keep in the pocket on the inside of the back cover.
Table of Contents

Benefits Described in This Booklet .......................................................................................................................... 1
Eligibility — Active, Casuals and Catastrophic Needs Medical Plan ................................................................. 3
  ENROLLMENT .................................................................................................................................................. 4
  ELIGIBILITY .................................................................................................................................................. 4
  COVERAGE REQUIREMENTS — SPECIAL RULES .......................................................................................... 6
  EXTENSION OF COVERAGE — SPECIAL RULES ....................................................................................... 6
  COBRA CONTINUATION COVERAGE — (ACTIVE, CASUAL, AND CATASTROPHIC NEEDS MEDICAL PLANS) ............. 11
  TOTAL DISABILITY — EXTENSION OF BENEFITS FOR YOU AND YOUR DEPENDENTS (ACTIVES AND CASUALS) .... 17
  TOTAL DISABILITY — EXTENSION OF MEDICAL BENEFITS FOR INDIVIDUAL’S DISABLING CONDITION ONLY
    (ACTIVES AND CASUALS) ......................................................................................................................... 17
  TOTAL DISABILITY — EXTENSION OF LIFE INSURANCE COVERAGE (ACTIVES AND CASUALS) ................................. 18
  EXTENSION OF COVERAGE BASED ON EMPLOYER CONTRIBUTIONS IN SPECIAL SITUATIONS — ACTIVE PLAN
    ONLY ......................................................................................................................................................... 18
  ALTERNATIVE COVERAGE THROUGH THE TRUST ...................................................................................... 18
  YOUR RETIREMENT AND POSSIBLE ELIGIBILITY UNDER THE WTWT RETIREE PLAN .................. 19
  OPTIONS AVAILABLE FOR RETIrees .............................................................................................................. 21
  RETIREE PRE-FUNDING PROGRAM ............................................................................................................ 22
Indemnity Medical Benefits for You and Your Covered Dependents ................................................................. 26
  HMO PLAN OPTIONS .................................................................................................................................. 26
  INDEMNITY MEDICAL BENEFITS SUMMARY .............................................................................................. 27
  CALENDAR YEAR DEDUCTIBLE .................................................................................................................... 30
  COINSURANCE ............................................................................................................................................. 31
  ANNUAL OUT-OF-POCKET MAXIMUM FOR COINSURANCE ........................................................................ 31
  OVERALL MEDICAL BENEFITS MAXIMUM ................................................................................................. 32
Eligible Expenses .................................................................................................................................................. 32
Care Management Programs ............................................................................................................................... 36
Indemnity Medical Benefit Exclusions .............................................................................................................. 39
Indemnity Medical Benefits Definitions ............................................................................................................ 42
Indemnity Prescription Drug Benefits for You and Your Covered Dependents ..................................................... 48
  INTRODUCTION ............................................................................................................................................ 48
  PLAN BENEFITS ......................................................................................................................................... 48
  HOW RETAIL PHARMACY SERVICE WORKS ............................................................................................ 49
  HOW HOME DELIVERY PHARMACY SERVICE WORKS ............................................................................. 50
  COVERED PRESCRIPTIONS ........................................................................................................................ 51
  PRESCRIPTION DRUG BENEFIT EXCLUSIONS............................................................................................ 52
Indemnity Mental Health and Chemical Dependency Benefits for You and Your Covered Dependents .......... 55
  THE PROGRAM AND HOW IT WORKS .......................................................................................................... 55
  SCHEDULE OF BENEFITS .......................................................................................................................... 57
  MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT EXCLUSIONS ........................................... 59
  MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT DEFINITIONS .............................................. 60
  APPEALS PROCESS FOR BEHAVIORAL HEALTH SERVICES ..................................................................... 63
Catastrophic Needs Medical Plan .......................................................................................................................... 66
  ELIGIBILITY ................................................................................................................................................. 66
  BENEFITS PROVIDED ................................................................................................................................. 66
  BUY UP OPTIONS ...................................................................................................................................... 67
Indemnity Dental Benefits for You and Your Covered Dependents — Actives Only .............................................. 69
  INDEMNITY DENTAL PLAN BENEFITS ....................................................................................................... 69
  INDEMNITY DENTAL BENEFIT EXCLUSIONS ............................................................................................ 72
  ORTHODONTIC BENEFIT FOR YOUR COVERED DEPENDENT CHILDREN ...................................................... 73
Vision Care Benefits for You and Your Covered Dependents ............................................................................... 75
  HOW TO USE THE PLAN WHEN CARE IS PROVIDED BY A VSP NETWORK DOCTOR .................. 75
  HOW TO USE THE PLAN FOR NON-VSP PROVIDER CARE .................................................................. 77
  VISION BENEFIT EXCLUSIONS .................................................................................................................. 77
Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits ......................................................... 81
  EMPLOYEE TERM LIFE INSURANCE ............................................................................................................ 81
  TERM LIFE INSURANCE FOR COVERED DEPENDENTS — SPOUSE AND CHILD(REN) .............................. 82
  EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .................................................. 82
# Benefits Described in This Booklet

<table>
<thead>
<tr>
<th>FULL BENEFITS</th>
<th>ACTIVES/CASUALS</th>
<th>WHO CAN BE COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Medical</td>
<td>Actives and Casuals</td>
<td>You and your dependents (if you select an HMO plan, that plan will provide your medical benefits)</td>
</tr>
<tr>
<td>Indemnity Prescription Drug</td>
<td>Actives and Casuals</td>
<td>You and your dependents (if you select an HMO plan, that plan will provide your prescription drug benefits)</td>
</tr>
<tr>
<td>Indemnity Mental Health and Chemical Dependency</td>
<td>Actives and Casuals</td>
<td>You and your dependents (if you select an HMO plan, that plan will provide your mental health and substance abuse benefits)</td>
</tr>
<tr>
<td>Indemnity Dental</td>
<td>Actives only</td>
<td>You and your dependents (if you reside in an area where an alternative dental plan is available, and you select it, that plan will provide your dental benefits)</td>
</tr>
<tr>
<td>Vision Care</td>
<td>Actives and Casuals</td>
<td>You and your dependents</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Actives and Casuals</td>
<td>You and your dependents</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Insurance</td>
<td>Actives and Casuals</td>
<td>Employees only</td>
</tr>
<tr>
<td>Weekly Time Loss</td>
<td>Actives only</td>
<td>Non-California Active Plan employees only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIMITED BENEFITS</th>
<th>ACTIVES</th>
<th>WHO CAN BE COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Medical Only – Catastrophic Needs Medical Plan</td>
<td>Actives covered under the National Master Freight Agreement with more than 60, but less than 100, compensable hours in a month</td>
<td>You and your dependents</td>
</tr>
</tbody>
</table>
Benefits Provided Through Health Maintenance Organization (HMO) Options

Alternate Medical Plans – Actives and Casuals

If you select an HMO plan, your medical, prescription drug, mental health, and chemical dependency benefits will be described in a separate booklet provided by the HMO. Your other benefits, general eligibility requirements, and other information are described in this booklet. HMO options are not available for individuals under the Catastrophic Needs Medical Plan. The following HMO plans are available as of the date of this booklet:

<table>
<thead>
<tr>
<th>STATE</th>
<th>HMO PLANS</th>
<th>ACTIVE/CASUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>PacifiCare of Arizona</td>
<td>Actives only</td>
</tr>
<tr>
<td>California</td>
<td>Kaiser Foundation Health Plan</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of California</td>
<td>Actives only</td>
</tr>
<tr>
<td>Colorado</td>
<td>Kaiser Foundation Health Plan of Colorado</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of Colorado</td>
<td>Actives only</td>
</tr>
<tr>
<td>Nevada</td>
<td>PacifiCare of Nevada</td>
<td>Actives only</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Presbyterian Health Plan</td>
<td>Actives only</td>
</tr>
<tr>
<td></td>
<td>Lovelace Health Plan</td>
<td>Actives only</td>
</tr>
<tr>
<td>Oregon</td>
<td>Kaiser Foundation Health Plan of Oregon</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>(includes Southwest Washington)</td>
<td>Actives only</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of Oregon</td>
<td>Actives only</td>
</tr>
<tr>
<td>Utah</td>
<td>Intermountain Health Care (Select Medical)</td>
<td>Actives only</td>
</tr>
<tr>
<td>Washington</td>
<td>Group Health</td>
<td>Actives only</td>
</tr>
</tbody>
</table>

Alternate Dental Plans — Actives Only

Alternate dental plans are provided by:

- Safeguard Dental in Arizona and California.
- Kaiser Foundation Health Plan of Oregon in Oregon and Southwest Washington.

If you choose an alternate dental plan, your dental benefits will be described in a separate booklet provided by the alternate dental plan.

Enrollment

If you reside in an area where HMO plans or alternate dental plans are available, you may choose between the optional coverage and the indemnity benefits described in this booklet at the time you begin participation with the Trust, during the annual open enrollment period or when an event giving rise to special enrollment rights occurs. If you elect an HMO or alternate dental plan, you must remain in that plan until the next open enrollment. See additional details on page 26.
Eligibility — Active, Casual, and Catastrophic Needs Medical Plan

This section explains the eligibility and enrollment provisions for the Active, Casual, and Catastrophic Needs Medical Plans. Different eligibility rules can apply depending on the collective bargaining agreement under which you work.
ENROLLMENT

Participant Data Form

When an employer first makes contributions to the Trust on your behalf, you will be sent a Participant Data Form. In order for you and your dependents to receive benefits under the Trust and avoid delays in claims processing, you must complete and return this form to your Area Administrative Office. Failure to return the form, complete it in full, or submit supplemental documentation necessary to establish eligibility for you or your dependents may result in a delay in processing or a denial of your claims. If you do not receive a Participant Data Form, call your Area Administrative Office.

Updating Participant Data Form

Changes in marital status, the dependents covered, or in your address, must be reported to your Area Administrative Office. See the Eligibility section for time limits on submitting this information. You may report these changes by submitting a revised Participant Data Form to your Area Administrative Office. Additional information may be requested to establish dependent eligibility. Call your Area Administrative Office for a Participant Data Form.

ELIGIBILITY

Eligible Employees—Active Plan (Full Benefits)

You are eligible for benefits under the Active Plan if you are an Active Regular Employee of an employer who is party to a Teamsters Union collective bargaining agreement, have the required number of compensable hours in a month, and the employer makes the required contributions on your behalf to the Trust. As of April 1, 2008, the following monthly compensable hour requirements must be met by Active Regular Employees to receive full benefits:

National Master Freight Agreement – 100 compensable hours per month;
Other Active Regular Employees – 60 compensable hours per month.

Eligible Employees — Casual Plan

You are eligible for benefits the Casual Plan if you are a casual employee of an employer who is party to a Teamsters Union collective bargaining agreement and who is making the required contributions on your behalf to the Trust for the purpose of providing health and welfare benefits and if you have the required number of shifts. If you are an eligible employee under the Active Plan, you are not eligible to participate in the Casual Plan.
Eligible Employees—Catastrophic Needs Medical Plan

A separate medical-only benefit plan (described on page 65 of this Booklet) is provided to Active Regular Employees working under the National Master Freight Agreement who have at least 60, but less than 100, compensable hours in a month. This optional eligibility rule does not apply to any other group of employees participating in the Trust.

Eligible Dependents — Active, Casual, and Catastrophic Needs Medical Plans

Eligible dependents are the same under all plans offered by the Trust. Eligible dependents are your:

- Legally married spouse.
- Unmarried children under age 19 who depend on you for support and who are:
  - Your own children, natural or adopted;
  - Your stepchildren or foster children; or
  - Children for whom you are required to provide medical coverage under a Qualified Medical Child Support Order.
- Unmarried children who depend on you for support can continue coverage after they reach age 19 in two situations:
  - A child age 19, or older, will be eligible until age 26, if he or she is a full-time student in an educational institution. School vacation, church missions, and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.
  - An unmarried eligible child who is physically or mentally incapable of self support at age 19 may continue under the plans while remaining incapacitated and dependent on you for support, if your own coverage is in effect. This also applies to a child who, while remaining eligible in the plans after age 19, becomes physically or mentally incapable of self-support.

To continue an eligible child’s health coverage under either of these provisions, you must provide proof of the child’s full-time student status or evidence of the child’s physical or mental incapacity prior to or within 31 days after the child’s coverage would otherwise terminate or the child would be first eligible to participate in the plans. The Trust may request additional proof as necessary to establish continued eligibility under these provisions.

Definitions Related to Dependent Eligibility

Legally Married Spouse — To be eligible, your marriage must be legally recognized by the state in which you reside. As a result, domestic partners are not covered. Common-law spouses are not eligible unless the state in which you reside legally recognizes your common-law marriage.

Adopted Children — Legally adopted children include children placed in your home pending adoption. Placement for adoption means you assume a legal obligation for total or partial support of a child in anticipation of adopting the child.

Foster Children — A child related to you by blood or marriage, living in your home, dependent on you for support, and being raised as your own. A foster child does not include a child...
temporarily living in your home, a child placed in your home by a social service agency which retains control of the child, or a child whose natural parent is in a position to exercise or share in parental responsibility and control.

**Stepchildren** — A child of your spouse, dependent on you for support and being raised as your own.

**Dual Coverage under the Trust**

If your spouse is eligible as an employee under the Trust, he or she will be eligible both as an employee and as a dependent. When both husband and wife are eligible employees, their children are eligible dependents of both. See pages 91 to 94 for information about coordination of benefits.

**Medical Child Support Orders**

The Trust will observe the terms of Medical Child Support Orders that the Trust finds to be qualified under the applicable provisions of ERISA. Employees or dependents may submit Medical Child Support Orders to their Area Administrative Office for review. Call your Area Administrative Office for additional information.

**Coverage Requirements**

**When Coverage Begins — Active Plan (Full Benefits)**

You become covered under the Active Plan for yourself and your eligible dependents on the first day of the second month following the initial month in which you have the required number of compensable hours for a participating employer, who makes the required Plan contributions to the Trust. As noted above, the required number of compensable hours for full benefits is 100 hours in a month for Active Employees covered by the National Master Freight Agreement and 60 hours in a month for other Active Employees. For example, you have the required number of compensable hours in January and the employer makes the required Plan contributions to the Trust in February your coverage will begin on March 1 under the lag month provision requirements.

**When Coverage Begins — Casual Plan**

You will become covered under the Casual Plan for yourself and your eligible dependents on the first day of the second month following the initial month in which you work the required number of shifts (at least 15 four-hour shifts per month of casual employment) for any participating employer who has made the required contributions for these Plan benefits. For example, you work 15 four-hour shifts in January and the employer makes the required Plan contributions to the Trust in February. Your coverage will begin on March 1 under the lag month provision requirements.

Coverage for all Plan benefits to which you and your eligible dependents are entitled begins at the same time, except as discussed in “When Coverage Begins for a New Dependent” and “Deferment of Life Insurance Coverage” below. Verification of incapacity will be requested at the time your coverage begins for children age 19 or older who you wish to cover under the Plan provisions dealing with physically or mentally incapacitated eligible dependent children.
When Coverage Begins — Catastrophic Needs Medical Plan

You become covered under the Catastrophic Needs Medical Plan as of the first day of the second month in which you have more than 60 hours, but less than 100 compensable hours, as an Active Employee under the National Master Freight Agreement. For example, if you work 65 hours in August, you will be covered under the Catastrophic Needs Medical Plan effective October 1st.

When Coverage Begins for a New Dependent

Children are eligible for all health benefits from birth, the time they are placed for adoption, or are otherwise acquired. Term life insurance, however, does not take effect until children are 14 days old.

A newly acquired spouse is eligible from the date of your marriage.

Remember that an updated Participant Data Form must be submitted when you add a new dependent. If you need a Participant Data Form, call your Area Administrative Office.

Deferment of Life Insurance Coverage

If you or an eligible dependent (except newborns) are confined in a hospital on the date life insurance coverage would normally begin, coverage will be deferred until you or your dependent are released from the hospital.

Continuation of Coverage Based on Employer Contributions — Active Plan

Once coverage begins, you and your eligible dependents will continue to have coverage for the second calendar month following the month in which you have the required number of compensable hours as an Active Regular Employee, providing your employer made the required contribution on your behalf for the hours you worked. For example, you have the required number of compensable hours in January and the employer makes the required Plan contribution to the Trust in February. Your coverage begins on March 1. If you work the required number of compensable hours in February, and the required continuation is made, this will provide coverage for you and your eligible dependents in April.

If you fail to receive the required number of hours of compensation to be eligible for coverage due to an on-the-job injury or an off-the-job injury or illness, your collective bargaining agreement may require your employer to continue to make contributions beyond the month you last earned eligibility. In the event of an on-the-job injury, the employer’s obligation to make continued contributions is for a period of up to 12 months after the Trust’s waiver of premium period is exhausted. In the event of an off-the-job injury or illness the employer’s obligation to make continued contributions is for a period of one month after the Trust’s waiver of premium period is exhausted. If your employer makes these contributions, the Trust will accept them and continue your coverage for the appropriate period. Contact your Area Administrative Office for further information. No waiver of premium applies and there is no obligation for the employer to make continued contributions while you are disabled if you become disabled while covered under the Catastrophic Needs Medical Plan.
If you lose coverage due to a disabling condition, you must contact your Area Administrative Office within 60 days of the onset of disability and complete the necessary forms to receive ongoing coverage through the Trust’s waiver of premium period. Disabling conditions must be certified by the treating physician.

**Continuation of Coverage Based on Employer Contributions — Casual Plan**

Once coverage has started, you and your eligible dependents will continue to have coverage for each calendar month following your initial eligibility so long as you work the required number of shifts as a casual employee, or have adequate hours in your Reserve Account, and provided your employer has made the required contribution on your behalf.

**Reserve Account — Casual Plan**

Eligibility for Casual employees is based on the number of four-hour shifts worked in a month. You must have 15 shifts each month to be eligible. If you are employed as a casual employee in excess of 30 four-hour shifts during any month, the excess shifts will be credited to your Reserve Account. The excess shifts in your Reserve Account will be used to continue your coverage under the Casual Plan if you do not have enough shifts in a given month, or to satisfy the shift requirement for becoming covered after previous termination under the Casual Plan. Any shifts used for this purpose will be deducted from your Reserve Account.

The maximum number of shifts that may be accumulated in your Reserve Account at any time is 90 shifts (six months of coverage).

All shifts in your Reserve Account will be canceled if you fail to be covered under the Casual Plan for 12 consecutive months.

**Eligibility and Termination Examples for Casual Employees**

- You are employed for at least 15 four-hour shifts in the month of May and the required contribution is made to the Trust in June. You become eligible for coverage on July 1.
- You are employed for 42 four-hour shifts in the month of May. The 12 shifts in excess of 30 shifts will be credited to your Reserve Account.
- You have accumulated 15 shifts in your Reserve Account. In August, you are employed for only 11 shifts which is not enough to continue coverage for October. Four shifts will be deducted from your Reserve Account to add to the 11 shifts you worked to satisfy the 15 shift requirement for coverage to be continued in October. This leaves a balance of 11 shifts in your Reserve Account.
- You are employed for eight shifts in the month of August. This is seven less than needed to continue coverage for October. There are only five shifts in your Reserve Account. Because the total of the employed shifts and those in your Reserve Account are fewer than the required 15, you will not be eligible in October. The five shifts in the reserve account will be held for future use, subject to cancellation if you are not eligible for 12 consecutive months.
- You have accumulated 60 shifts in your Reserve Account. You were not employed during August. Coverage for the month of October will be paid by deducting 15 shifts from the 60 in your Reserve Account. This leaves 45 shifts in your Reserve Account. Eligibility will
continue until the combination of Reserve Account and any shifts credited in a month falls below 15 shifts.

For information about termination of eligibility see page 10. For information about eligibility for retired employees, see page 19.

**Military Leave**

The Trust will continue your coverage if you are involuntarily called to active duty status from the military reserves or national guard for military-related service, excluding military service lasting 31 days or less. If your military service lasts more than 31 days, your coverage will end on the day you enter active military coverage. You will be eligible to continue your coverage through self-payment under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Continuation rights under USERRA are administered in accordance with the Trust’s COBRA provisions.

Your employer may have an obligation to make contributions under a bargaining agreement providing for participation in the Trust. The National Master Freight Agreement in place as of the date of this Booklet provides: “In addition to any contribution required under USERRA, the Employer shall continue to pay health and welfare contributions for regular active employees involuntarily called to active duty status from the military reserves or the National Guard for military-related service, excluding civil disturbances or emergencies. Such contributions shall only be paid for a maximum period of eighteen (18) months.”

If you qualify for reemployment under USERRA after you return from military service, your coverage under the Trust will be restored immediately.

**Family and Medical Leave Act**

Additionally, under the Family and Medical Leave Act (FMLA) your employer may be required to continue contributions on your behalf while you are on family or medical leave. If your employer makes these contributions, the Trust will accept them and continue your coverage for the appropriate period. Contact your Area Administrative Office for further information.

**Coverage During a Delinquency Through Self-Payments**

If your coverage is interrupted due to an employer delinquency, you may continue coverage for yourself and your eligible dependents for up to six months by making self-payments at the regular employer contribution rate. Coverage under this section must be continuous. Your Area Administrative Office will notify you about the delinquency and payment due date. If the employer makes retroactive contributions directly, or as a result of a collection action by the Trustees, your self-payments will be refunded for any matching months.
Coverage for Change of Operations Transferees — Active Employees Only

Occasionally, participants are transferred by their employers from locations within the western states to locations in other parts of the country, according to Change of Operations Committee decisions made under the terms of the National Master Freight Agreement. Under the provisions of the National Master Freight Agreement, the employer is required to continue pension and health and welfare contributions for transferred participants to the Trust such contributions were paid into on behalf of the participant prior to the location change. Participants who are transferred out of the western states pursuant to change of operations decisions continue to earn Trust contributions, and continue to have Trust coverage, while located elsewhere. Change of operations participants and their dependents must continue to meet all other eligibility requirements of the Trust.

Participants who were transferred according to change in operations decisions made prior to August 1, 1994, should contact their former Area Administrative Offices with questions about eligibility and benefits.

Participants who were transferred according to change in operations decisions made on or after August 1, 1994, should contact Southwest Administrators at 877-350-4792 with questions.

When Your Coverage Ends

All benefits for you and your dependents will end when any of the following events occur:

- The last day of the preceding month for any month in which the eligibility requirements for the Active Plan, Casual Plan, or Catastrophic Needs Medical Plan are not met.
- The last day of the preceding month for any month in which the required employer contribution (or any applicable employee self-payment) is not made.
- The day the plan or the Trust terminates.
- The day of your death (and the last day of the last month of your earned coverage for your dependents).
- The day you are no longer eligible under an applicable collective bargaining agreement, or written special agreement, or are otherwise not eligible under the Trust’s rules.
- The day your employer fails to pay the proper rate and your bargaining unit is terminated from participation in the Trust, as determined by the Trustees under the Trust’s non-conforming rate policy.
- The day you enter active military duty (except for certain defined situations during which your employer may be required to make contributions under some collective bargaining agreements or for periods of temporary active duty of less than 31 days).

When Your Dependents’ Coverage Ends

All benefits for your dependents end on the day in which any of the following events occur:

- You, as the participant, lose your coverage.
- Your dependent fails to meet the plan’s eligibility requirements for dependents.
- The last day of your last month of earned coverage following the date of your death.
- Your dependent enters active military service (except for periods of temporary active duty of less than 31 days).
EXTENSION OF COVERAGE — SPECIAL RULES

Possible Ways to Extend Coverage

Coverage for you and your dependents may be extended in certain situations. The provisions under which extended coverage is available and the plan options to which they apply are:

- COBRA Continuation Coverage (Active, Casual, and Catastrophic Needs Medical Plans);
- Total Disability — Extension of Medical Benefits for You and Your Dependents – (Actives, Casuals);
- Total Disability — Extension of Medical Benefits for Individual’s Disabling Condition Only (Actives, Casuals);
- Total Disability — Extension of Life Insurance Coverage – (Actives, Casuals);
- Extension of Coverage Based on Employer Contributions in Special Situations (Actives Only);
- Alternative Coverage through the Trust.

COBRA CONTINUATION COVERAGE – (ACTIVE, CASUAL, AND CATASTROPHIC NEEDS MEDICAL PLANS)

COBRA is a federal law that requires certain group health plans to offer participants and their dependents the opportunity to extend their health coverage in specific situations when coverage under the plan would otherwise terminate. COBRA continuation coverage requires self-payments by you and your dependents and also requires that you notify the Trust in certain situations. Your rights and responsibilities under COBRA are explained on pages 11 to 17.

Self-Payments for Coverage (COBRA)

Under the circumstances described below, you, your lawful spouse, and your eligible dependent children each have the independent right to elect to continue your Trust health coverage beyond the time coverage would ordinarily have ended pursuant to a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Trust has no other self-payment provision.

Notices to Trust Concerning COBRA

The Area Administrative Office serving your area is responsible for administering COBRA continuation rights for you. All communications must:

- Be made in writing;
- Identify you and the eligible employee, if different;
- Identify the Trust’s name and be sent to your Area Administrative Office.

The Area Administrative Offices, the geographical areas they serve and their addresses are listed on page 118 of this booklet.
Qualifying Events

You (as the participating employee) have the right to elect continuation of your health coverage from the Trust if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your spouse has the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The participating employee’s termination of employment or reduction in hours of employment;
- Death of the participating employee;
- Divorce or legal separation of the participating employee;
- The participating employee becoming eligible for Medicare.

A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:

- The participating employee’s termination of employment or reduction in hours of employment;
- Death of the participating employee;
- Divorce or legal separation of the participating employee;
- The participating employee becoming eligible for Medicare;
- The child no longer qualifying as an eligible dependent under the plan.

COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Trust of a loss of coverage resulting from a divorce, legal separation, or a child losing dependent status. If you or your eligible dependents have a loss of coverage because of these events, you must notify your Area Administrative Office at the address shown in the Plan Booklet within 60 days of the date of the above qualifying events. Your written notice must identify the individual who has experienced the qualifying event, the eligible employee’s name, the Trust’s name, and the qualifying event which occurred. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the plan.

Your employer is responsible for informing the Trust of any other qualifying event. The Board of Trustees, though, reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA

Once the Trust has received proper notice that a qualifying event has occurred, it will notify you, your lawful spouse, and each of your eligible dependents of your independent right to elect continuation coverage. A written election must be made within 60 days from the date coverage would otherwise end or 60 days from the date a COBRA notice is furnished by the Trust, if later. Unless otherwise stated on the election form, an election of COBRA coverage under the Trust by
one family member covers all other eligible members of the same family. Your written election must be sent to your Area Administrative Office. Failure to elect continuation coverage within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

**Available Coverage**

You and/or your eligible dependents may elect the following coverages:

- **Active Plan Participant - Medical** (including mental health and chemical dependency) and prescription drug only; or medical (including mental health and chemical dependency), prescription drug, vision, and dental;
- **Casual Plan - Medical** (including mental health and chemical dependency) prescription drug, and vision;
- **Catastrophic Needs Medical Plan** – Medical benefits under the Catastrophic Needs Medical Plan only or alternatively the COBRA benefits available to Active Plan Participants.

You may only continue coverage in the Plan option you had as of your qualifying event with the exception of participants in the Catastrophic Needs Medical Plan who may also elect the options available to Active Plan participants. If you elect COBRA continuation coverage, you may change coverage to or from an HMO option available through the Trust for which you are eligible during the Trust’s annual open enrollment period.

COBRA continuation coverage is not available for time loss or life and accidental death and dismemberment benefits. If you elect to continue medical and prescription drug coverage only, you cannot add dental and vision coverage, nor can you switch to medical and prescription drug coverage only if you have elected to continue medical, prescription drug, dental, and vision coverage. Similarly, if you have elected the Catastrophic Needs Medical Plan, you cannot subsequently switch to the COBRA benefits available under the Active Plan.

**Adding New Dependents**

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. However, if you elect COBRA continuation coverage, and acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may add the new dependent to your COBRA coverage by providing written notice to the Trust within 60 days of acquiring the new dependent. The written notice must identify the employee, the new dependent, the Trust, the date the new dependent was acquired, and be mailed to your Area Administrative Office. Children acquired through birth, adoption, or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs as discussed on page 15.

**Continuous Coverage Required**

Your coverage under COBRA must be continuous from the date your Trust coverage would have otherwise ended if COBRA continuation coverage was not elected.

**Cost**

A qualified beneficiary must pay the entire cost of the continuation coverage. The Trust uses a composite rate which means that you pay the same monthly rate if you are covering one person or
an entire family. The cost for the coverage available through the Trust is set annually and depends on the option you choose. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the COBRA coverage options available to you. If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your or your dependent’s disability.

**Monthly Self-Payments Required**

You or your eligible dependents are responsible for the full cost of COBRA continuation coverage. Self-payments for continuation of coverage are due on the first of each month for that month’s coverage and must be sent to your Area Administrative Office at the address shown on Page 118 of this Plan Booklet. Coverage will be terminated if payment is not received by the Trust Office within 30 days of this due date. Checks that are received and do not clear the bank due to insufficient funds are considered non-payment. The only exception is that the self-payment for the period preceding the initial election of COBRA coverage may be made up to 45 days after the date of election. Your initial payment must cover all months for which you want coverage and be retroactive to when your Trust coverage ended. If your initial payment is not received or postmarked within 45 days of when you elected COBRA coverage, your right to COBRA continuation coverage will be lost.

**Length of COBRA Continuation Coverage**

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours. For all other qualifying events (death of employee, divorce, or legal separation from employee, employee becoming Medicare eligible, or a child no longer qualifying as a dependent under the Plan) continuation coverage can last for up to 36 months. COBRA continuation coverage will end, however, on the last day of the monthly premium payment period if any one of the following occurs before the end of the maximum available continuation period:

- A required self-payment is not paid to your Area Administrative Office on a timely basis for the next monthly coverage period;
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking COBRA continuation coverage);
- You or your eligible dependent provide written notice that you wish to terminate your coverage;
- You or your eligible dependent become entitled to Medicare benefits after the date of your COBRA election; or
- The date the Plan terminates or the date your employer no longer participates in the Plan unless your employer or its successor does not offer another health plan for any classification of its employees which formerly participated in the Trust.

**Length of COBRA Continuation Coverage — Disabled Participants**

If you have lost coverage because of a termination of employment or reduction of hours and you, your spouse, or any dependent covered by the Trust is determined by the Social Security
Administration to be disabled by no later than the first 60 days of COBRA continuation coverage, your entire family can receive an additional 11 months of COBRA continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify your Area Administrative Office in writing within 60 days of the latest of your qualifying event, the mailing of the COBRA notice, or receipt of your Social Security Disability Determination. Notice must also be provided prior to the end of your initial 18-month period of COBRA continuation coverage. If the disabled individual extends coverage based on this provision and is subsequently found not to be disabled, you must notify your Area Administrative Office in writing within 30 days of this determination.

Length of COBRA Continuation Coverage — Second Qualifying Event

Eligible dependents who are entitled to continuation coverage as the result of the employee’s termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 18 months of COBRA continuation coverage. Possible second qualifying events are the employee’s death, a divorce or legal separation from the employee, a child losing dependent status, or the employee becoming eligible for Medicare during the initial 18 months of COBRA continuation coverage.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify his or her Area Administrative Office in writing within 60 days of the second qualifying event. The written notice must identify the employee, the person continuing coverage, and the nature of the second qualifying event, and must be sent to your Area Administrative Office. Failure to give such timely written notice of a second qualifying event will cause the individual’s coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage extend beyond a total of 36 months.

Length of COBRA Continuation Coverage – Medicare Entitlement

If the employee has an 18-month qualifying event after becoming entitled to Medicare, dependents may continue coverage until the later of 18 months from the date coverage would otherwise end or 36 months from the date the employee became eligible for Medicare.

Special Rules for Assistance-Eligible Individuals

Special rules apply to Employees (and their dependents) who lost coverage from the Trust between September 1, 2008 and December 31, 2009 because of an involuntary termination of employment. Such individuals who elect COBRA coverage in a timely manner shall pay 35% of the applicable premium for COBRA continuation until the earliest of the following events:

- Nine months have passed since the individual was first eligible for the 35% COBRA self-payment rate;
- The time period the individual would be eligible for COBRA expired;
- The individual becomes eligible for other group health coverage or entitled to Medicare;
- The individual otherwise fails to meet the requirements for COBRA coverage.

Individuals who lost coverage because of an involuntary termination of employment on or after September 1, 2008 but before March 1, 2009 shall have an opportunity to elect COBRA coverage. Such individuals shall receive a new election notice for COBRA coverage from the Trust and
shall have 60 days after the date of the notice to elect COBRA coverage. If coverage is elected, it shall start March 1, 2009. Coverage will not be retroactive.

Any individual who requests the reduced subsidy and is rejected may make an expedited appeal to the Department of Labor. Details about the expedited appeal procedure are available from the Department of Labor or your Area Administrative Office.

Any individuals who receive premium assistance towards COBRA coverage, who is not eligible, may be subject to a penalty of 110% of the premium reduction unless the failure to provide notices was the result of reasonable cause.

**Effect of Not Electing Continuation Coverage**

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law:

- You can lose the right to avoid having pre-existing condition exclusions apply to you under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap;
- You can lose the right to purchase guaranteed individual health coverage that does not impose a pre-existing condition exclusion if you do not obtain continuation coverage for the maximum time available to you; and
- You should be aware that federal law gives you special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse’s plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

**Additional Information**

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration or visit its website at www.dol.gov/ebsa.

To help ensure that you receive necessary notices, you should notify your Area Administrative Office if your address or that of any family member changes. You should keep a copy of any written notices you send the Trust.

**USERRA Military Service**

If an individual has lost coverage because he or she has entered military service for longer than 31 days and is covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), the individual can elect to self-pay for coverage for up to a maximum of 24 months. USERRA rights under the Trust are governed by the same rules that apply to COBRA continuation coverage.
Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA continuation coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. However, if you have Medicare or other group health coverage at the time you elect COBRA continuation coverage, you can be eligible for both.

If you have coverage under a Trust-sponsored Plan based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay primary and the Trust will coordinate with Medicare and pay secondary. Current employment status means you are still at work or have received short-term disability benefits for less than six months. If you have Medicare coverage based on end-stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute. If you have other group health coverage, it will pay primary and the Trust’s continuation coverage will be secondary.

TOTAL DISABILITY — EXTENSION OF BENEFITS FOR YOU AND YOUR DEPENDENTS (ACTIVES AND CASUALS)

If you become totally disabled while eligible through employer paid contributions, all Plan benefits for you and your eligible dependents may be continued for up to six months for Active Plan employees and up to three months for Casual Plan employees. No extension of benefits is available while under the Catastrophic Needs Medical Plan. To receive continued coverage, you must be totally disabled and provide your Area Administrative Office with a doctor’s certification of your total disability in a form acceptable to the Trust. If you are still totally disabled at the end of the three or six-month period, you may elect to continue coverage through the COBRA continuation provisions outlined above.

Benefits provided under this section will end if you cease being totally disabled, if benefits paid reach the lifetime maximum under the Plan, or the Plan terminates.

TOTAL DISABILITY — EXTENSION OF MEDICAL BENEFITS FOR INDIVIDUAL’S DISABLING CONDITION ONLY (ACTIVES AND CASUALS)

If you or a covered dependent is totally disabled and under the care of a physician when your coverage terminates, you or your dependent may continue to receive medical benefits for covered services related to the illness or injury which caused the total disability. Under this provision, your total disability must prevent your performing any occupation. You must apply for this extended coverage no later than 60 days after your coverage would otherwise end.

Benefits under this provision will end if you cease being totally disabled, if benefits paid reach the lifetime maximum under the Plan, the Plan terminates, or you have been covered under this provision for 18 months. The Extension of Medical Benefits for Individual’s Disabling Condition may be selected as an alternative to COBRA continuation coverage or, if you elect COBRA after COBRA continuation coverage ends or terminates.
When this extension applies, it will operate only to the extent that coverage for medical care is not otherwise provided for the person through the Trust.

**TOTAL DISABILITY — EXTENSION OF LIFE INSURANCE COVERAGE (ACTIVES AND CASUALS)**

If you become totally disabled before you reach age 60, your term life insurance may be continued by the Trust as long as you remain totally disabled. You must submit written proof of your total disability to the Trust’s life insurance carrier no later than one year after the date you become disabled. You will be required to periodically submit proof of your continuing disability but not more than once each year. This provision will end under certain conditions. In no event will it continue past attainment of age 65.

**EXTENSION OF COVERAGE BASED ON EMPLOYER CONTRIBUTIONS IN SPECIAL SITUATIONS — ACTIVE PLAN ONLY**

If you would otherwise lose coverage because you have failed to work the required number of hours, your employer may be required to make contributions to the Trust on your behalf in special situations. These situations are described on page 7.

**ALTERNATIVE COVERAGE THROUGH THE TRUST**

The Trust’s self-funded medical (including chemical dependency and mental health), prescription drug, dental, and vision programs offer no conversion option.

If you participate in an HMO option available through the Trust, you may have alternative coverage options, including a conversion option and self-payment rights under state continuation laws which may differ from COBRA. If you participate in an HMO option and wish more detail, please contact the HMO. The contact addresses for the HMO options available through the Trust are listed on page 120 of your Plan booklet or are available from your Area Administrative Office.

Generally, you must apply for HMO conversion coverage within strict time limits.(often 31 days or less). You should be aware that if you enroll in an individual conversion plan, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends. If you elect COBRA, you may elect to participate in an HMO for which you are eligible during the Trust’s annual open enrollment period.

If you cease active employment and retire, you and your dependents may be eligible for benefits under the Trust’s Retirees Health and Welfare Plan (“Retiree Plan”). Eligibility and benefits under the Retiree Plan are explained in a separate booklet available from the Trust Office. **Your application to participate in the Retiree Plan must be submitted no later than 90 days following the later of your Western Conference of Teamsters pension effective date or the end of your WTWT Active/Casual Plan coverage.**
Finally, if you have lost coverage because your employer has failed to make the required contributions, the Trust will not provide COBRA continuation coverage but will allow you to pay the employer contribution rate for up to six months.

Conversion of Term Life Insurance

You may be able to convert your term life insurance to one of a number of individual policies. See “Changing to an Individual Policy” on page 81.

YOUR RETIREMENT AND POSSIBLE ELIGIBILITY UNDER THE WTWT RETIREE PLAN

If you retire from active employment and begin receiving your Western Conference of Teamsters Pension benefit or another Teamster pension trust benefit, you and your dependents may be eligible for benefits under the Retiree Plan. Eligibility and benefits under the Retiree Plan are explained in a separate Retiree Plan booklet. To assist you in planning for your retirement, the following outline of the Retiree Plan’s current eligibility rules is provided.

A Casual employee is not eligible for benefits under the Trust’s Retiree Plan unless he or she meets the Retiree Plan eligibility requirements as an Active Regular Employee. For a full description of the Retiree Plan eligibility rules, please refer to the Retiree Plan booklet or call your Area Administrative Office.

Application for Retiree Plan Coverage — 90-Day Rule

Your Teamster pension benefit does not include retiree health coverage. To receive Retiree Plan coverage from the Trust, you must apply separately. To assure that your Retiree Plan application is handled in a timely manner, it should be submitted to your Area Administrative Office prior to your contemplated retirement date. Your Retiree Plan application must be submitted to your Area Administrative Office no more than 90 days after the later of:

- Your Western Conference of Teamsters pension effective date; or
- The end of your WTWT Active/Casual Plan coverage.

An application submitted more than 90 days after the later of the two events listed above, will not be accepted and you and your dependents will not be eligible for Retiree Plan coverage.

In addition to this timely application requirement, your coverage under the WTWT Active/Casual Plan and the Retiree Plan must be continuous unless you qualify for one of the following exceptions (which are discussed in more detail in the Retiree Plan Booklet):

- You qualify for a postponement or suspension of Retiree Plan coverage based on other medical benefits being available;
- You irrevocably elect to defer your Retiree Plan coverage until you are Medicare eligible; or
- You have submitted an application to the Western Conference of Teamsters Pension Plan and you elect to defer your Retiree Plan coverage until your application is approved. If you make this election your Retiree Plan coverage will not start until the first of the month following the month in which your pension application is approved.
To utilize any of these postponement-of-coverage options, you must still apply for Retiree Plan coverage in the time period referenced above.

**Eligibility under the Retiree Plan requires:**

1. **Retirement after employment with a contributing employer to the Trust**
   You have been actively employed with an employer who contributed on your behalf to the Trust.

2. **No other group coverage**
   You are not eligible as an active employee under any group health care or service-type plan of benefits.

3. **Must be age 55 or older unless qualified for “PEER” pension**
   You are at least 55 years of age, or if younger than 55, you qualified for retirement under the “PEER” retirement formula as provided by the Western Conference of Teamsters Pension Trust, or under a comparable formula from any other Teamsters Pension Trust.

4. **Must be receiving a Teamster pension**
   You have retired under the Western Conference of Teamsters Pension Trust, or any other Teamster Pension Trust, and are receiving a monthly retirement benefit from that Trust. If you are not receiving a monthly retirement benefit because your employer has not made pension contributions to the Pension Trust, you may still be eligible if you meet all of the other eligibility requirements and your employer has been a contributing employer to this Trust continuously for at least ten years.

5. **Must have earned 60 months of Trust contributions within prior 84 months (60/84 Rule)**
   You have been covered by this Trust under a collective bargaining agreement accepted by the Trust and have earned 60 months of Trust contributions within the 84 months immediately preceding your pension effective date (Western Conference of Teamsters Pension Trust or any other Teamsters Pension Trust). The requirement for 60 months of Trust contributions is referred to as the “required months of Trust contributions.” The requirement that the Trust contributions be earned in an 84-month time frame immediately preceding your pension effective date is referred to as the “qualifying period.”

**Alternative Eligibility Test — Long-Term Career Employees**

If you fail to qualify under the 60/84 rule you may, be eligible if: (a) you have earned 36 months of Trust employer contributions within the 84 months immediately preceding your pension effective date; and (b) your overall employment history includes a cumulative total of 180 months, or more, of Trust contributions (or Trust contributions combined with contributions to another IBT health and welfare trust which covers the same work classifications as this Trust) within the 300 months immediately preceding your pension effective date.

Information concerning the number of months of Trust contributions that have been made on your behalf during the qualifying period is available from your Area Administrative Office. In determining whether you have had the required months of Trust contributions, the following months may, if necessary, be included:

- If your employer has been delinquent in making Trust contributions, one month of credit will be given for each month of delinquency, up to a total of 12 months.
• If you have been disabled and unable to work, one month of credit will be given for each month of disability, up to a total of 12 months.

• If you have received benefit eligibility under the Casual Plan under a WTWT collective bargaining agreement, one month of credit will be given for each month of such coverage up to a total of six months.

• If you have received benefit eligibility under the Catastrophic Needs Medical Plan under a WTWT collective bargaining agreement, one month of credit will be given for each month of such coverage up to a total of six months.

• If you have made COBRA continuation coverage self-payments, one month of credit will be given for each month of continuation coverage, up to a total of six months.

Note: If you leave active employment because of disability and have applied for a disability retirement from the Western Conference of Teamsters Pension Trust, or any other Teamsters Pension Trust, and if your disability retirement effective date is extended because of a delay in obtaining a related social security award, the 84-month qualifying period will be extended by one month for each month of delay but not to exceed 12 additional months.

6. Must make required self-payments
You must agree to make monthly Retiree Plan self-payments for yourself, and for your spouse for whom coverage is desired, in an amount determined by the Board of Trustees. To continue eligibility, these payments must be made in a timely manner. The Board of Trustees has the right to change the self-payment rates from time to time.

Please make note that if your last employer ceases to participate in the Trust (i.e., becomes a withdrawn employer); you and your spouse will be charged a self-payment rate which reflects the “full cost” of the Retiree Plan benefit.

OPTIONS AVAILABLE FOR RETIREES

In addition to immediate enrollment in the Retiree Plan, you or your spouse have the following additional options:

Postponement or Suspension of Coverage When Other Benefits Are Available

You or your spouse can suspend or postpone your Retiree Plan coverage if you have other employment-related health coverage. If you have met the Retiree Plan eligibility rules and wish to suspend your Retiree Plan coverage, contact your Area Administrative Office for the necessary form. If you qualify, no self-payments will be required while your coverage is suspended. No benefits will be provided by the Retiree Plan while you have suspended Trust coverage due to other group health coverage.

When you lose your other coverage, contact your Area Administrative Office within 30 days to resume your Retiree Plan coverage. Your Area Administrative Office will require documentation that your other group health coverage has been continuous and has not terminated from the date you requested a suspension until the date you request Retiree Plan coverage to resume. They will advise you of your monthly self-payment amount. When the documentation and self-payment is received, your Retiree Plan coverage will begin or resume.
Deferral of Coverage until Medicare Eligible

If you or your spouse become eligible to participate in the Retiree Plan on or after September 1, 2002, you can make a one-time election that defers Retiree Plan participation until you are Medicare eligible. Under this option, there is no requirement that you or your spouse have other health coverage while you are not participating in the Retiree Plan. Once this deferral election is made, your choice is irrevocable, and you cannot resume participation in the Retiree Plan until you are Medicare eligible. To select this option, you must submit a deferral request to your Area Administrative Office within the same 90-day period you have for electing to initially participate in the Retiree Plan. You must then notify your Area Administrative Office within 30 days of your becoming Medicare eligible to receive Retiree Plan coverage.

RETIREE PRE-FUNDING PROGRAM

The Trust has established the Retiree Pre-Funding Program to help pre-fund Retiree Plan costs.

How the Program Works

Eligibility

Eligibility to participate in the Retiree Pre-Funding Program is the same as for the Retiree Plan itself. If you are not eligible for the Retiree Plan, you will not be eligible for the Retiree Pre-Funding Program. Additionally, retirees who must pay the full cost of the Retiree Plan (such as employees of withdrawn employers and retirees who are already Medicare eligible with a Western Conference of Teamsters Pension effective date before August 1, 2003) will not receive any subsidy from the Retiree Pre-Funding Program.

Credits

There are two types of credits under the Retiree Pre-Funding Program. The first is for past service. This credit is based on your service with Trust participating employers prior to August 1, 2003. All non-Medicare retirees who retired with a Western Conference of Teamsters Pension effective date before August 1, 2003 who are eligible for a reduced rate under the Retiree Plan will receive 10 years of past service credit at $30 per year (or $300 per month) from the Retiree Pre-Funding Program. This credit will be applied to the cost of the Retiree Plan. As noted above, retirees from employers that no longer contribute to the Trust and Medicare eligible retirees will not receive any credit.

If you retired with a Western Conference of Teamsters Pension effective date on or after August 1, 2003, you will receive credits both for past service (for example, years worked with WTWT employers before August 1, 2003) and a credit for future service based on years worked with WTWT employers after August 1, 2003. The credit for service before August 1, 2003 (“past service”) will be based upon 50% of the employee’s years with a WTWT employer to a maximum of 10 years. The value of each year of this service credit will vary depending on whether if the employee retires before age 57 or after. Employees who retire at age 57 or later (up to Medicare age) receive a greater credit.

Additionally, if you retire with a Western Conference of Teamsters Pension effective date on or after August 1, 2003 you will receive credits for future service. You will receive one year of
future service for each 12 months of contributions made to the Trust on your behalf beginning with August 2003. Again, the value of the service earned on or after August 1, 2003 (“future service”) will also vary depending on if you retire before age 57. Employees who retire with a Western Conference of Teamsters Pension effective date on or after August 1, 2003 and are 57 or older will receive a greater credit.

What Credits Are Available

The chart below summarizes the credits available to you. If you retire with a Western Conference of Teamsters Pension effective date on or before August 1, 2003, row 1 applies to you. If you retire with a Western Conference of Teamsters Pension effective date after August 1, 2003, rows 2 through 4 apply to you depending on your age when you retire and if you are Medicare eligible.

Retirement date for eligibility and crediting purposes is based on your actual Western Conference of Teamsters Pension effective date.

<table>
<thead>
<tr>
<th>Row</th>
<th>Retirement Date</th>
<th>Past Service Credit (Years in WTWT On or Before 8/1/03)</th>
<th>Future Service Credit (Years in WTWT after 8/1/03)</th>
<th>Availability of Credit before Medicare Eligibility</th>
<th>Availability of Credit upon Medicare Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-Medicare Retired prior to August 1, 2003</td>
<td>All provided 10 years of past service at $30 per year or $300 per month</td>
<td>None</td>
<td>Past service credit</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Retired on or after August 1, 2003 and prior to age 57</td>
<td>50% of past service up to a maximum of 10 years at $30 per year</td>
<td>All years of future service earned after August 1, 2003 at $30 per year</td>
<td>All years of past and future service at $30 per year</td>
<td>All years of past and future service at $15 per year (past service subject to 10-year maximum)</td>
</tr>
<tr>
<td>3</td>
<td>Retired on or after August 1, 2003 and after reaching age 57</td>
<td>50% of past service up to a maximum of 10 years at $40 per year</td>
<td>All years of future service earned after August 1, 2003 at $40 per year</td>
<td>All years of past and future service at $40 per year</td>
<td>All years of past and future service at $15 per year (past service subject to 10-year maximum)</td>
</tr>
<tr>
<td>4</td>
<td>Retired on or after August 1, 2003 and after becoming Medicare eligible</td>
<td>50% of past service up to a maximum of 10 years at $25 per year</td>
<td>All years of future service earned after August 1, 2003 at $25 per year</td>
<td>None</td>
<td>All years of past and future service at $25 per year (past service subject to 10-year maximum)</td>
</tr>
</tbody>
</table>

Retirees who were eligible for Medicare prior to August 1, 2003 will not receive any credits.
Conditions for Receipt and Use of Credits

There are conditions for the receipt and use of credits from the Retiree Pre-Funding Program:

- Credits may be applied only toward the monthly self-payment required by the Retiree Plan. They may not be used for any other Plan or health coverage.
- If you do not qualify or terminate your participation in the Retiree Plan, you lose your right to the credit.
- Credits cannot be cashed out and are not subject to assignment, alienation, attachment, and garnishment.
- Credits are not vested. The Board of Trustees reserves the right to change or modify the Retiree Pre-Funding Program and the Retiree Plan, as required.
- Credits available under the Retiree Pre-Funding Program will not exceed the cost of the Retiree Plan option in which you participate.
- If your last employer no longer participates in the Trust or leaves the Trust after you retire, you will lose any credit for your years with the Trust prior to August 1, 2003 (“past service”).
- Retirees who must pay the full cost of the Retiree Plan (employees of withdrawn employers) will not receive any credit.
- Retirees who were eligible for Medicare prior to August 1, 2003 will not receive any credits.
- Spouses do not receive any credit unless the cost of the selected coverage option is less than the available subsidy. Then, the rest of the retiree’s monthly subsidy can be applied toward the cost of the spouse’s coverage.

Retiree Plan Benefits Not Guaranteed

Benefits under the Retiree Plan and the Retiree Pre-Funding Program are not guaranteed. Benefits are provided on a month-to-month basis, and are financed from a portion of the employer contributions paid for active employees and from retiree and spouse self-payments. The Board of Trustees reserves the right to modify or terminate the Retiree Plan and the Retiree Pre-Funding Program.

Retiree Plan Booklets Available from Area Administrative Offices

For a copy of the Retiree Plan booklet, or information about the Retiree Plan, contact your Area Administrative Office.
This section explains the indemnity medical benefits available to Active and Casual Plan participants and their dependents. These indemnity medical benefits do not apply if you have selected an HMO medical plan.

These provisions apply to individuals under the Catastrophic Needs Medical Plan, but the deductibles, coinsurance, and maximum benefits differ. See page 66 for details.
Indemnity Medical Benefits for You and Your Covered Dependents

HMO Plan Options

You may select an HMO plan if you live within the service area of an HMO plan listed below. If you select an HMO plan, your medical, prescription drug, and mental health and chemical dependency benefits will be provided through your HMO. Vision care benefits, life, accidental death and dismemberment, dependent term life insurance, and weekly time loss (if you are an Active, not living in California) will be provided through the Trust.

Rules for Electing and Revoking Election of HMO Plan Coverage

If you live within the service area of an HMO plan listed below, you will have an opportunity at the time you become initially eligible and during the annual open enrollment to choose whether to participate in an HMO plan. If no election is made, you will automatically receive the indemnity medical benefits and other benefits described in this booklet. If you have previously elected an HMO plan, that election will be honored until you revoke it. Contact your Area Administrative Office for additional information about your HMO plan options.

Annual open enrollment is held from July 15th to August 15th each year for a September 1st effective date. During this period you will be sent enrollment materials explaining the options available to you. If you do not receive enrollment materials, contact your Area Administrative Office for additional copies.

HMO Plans Available

The following HMO plans are available:

<table>
<thead>
<tr>
<th>STATE</th>
<th>HMO PLANS</th>
<th>ACTIVES/CASUALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>PacifiCare of Arizona</td>
<td>Actives only</td>
</tr>
<tr>
<td>California</td>
<td>Kaiser Foundation Health Plan</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of California</td>
<td>Actives only</td>
</tr>
<tr>
<td>Colorado</td>
<td>Kaiser Foundation Health Plan of Colorado</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of Colorado</td>
<td>Actives only</td>
</tr>
<tr>
<td>Nevada</td>
<td>PacifiCare of Nevada</td>
<td>Actives only</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Lovelace Health Plan</td>
<td>Actives only</td>
</tr>
<tr>
<td></td>
<td>Presbyterian Health Plan</td>
<td>Actives only</td>
</tr>
<tr>
<td>Oregon</td>
<td>Kaiser Foundation Health Plan of Oregon</td>
<td>Actives and Casuals</td>
</tr>
<tr>
<td></td>
<td>PacifiCare of Oregon</td>
<td>Actives only</td>
</tr>
<tr>
<td>Utah</td>
<td>Select Med</td>
<td>Actives only</td>
</tr>
<tr>
<td>Washington</td>
<td>Group Health</td>
<td>Actives only</td>
</tr>
</tbody>
</table>
# Indemnity Medical Benefits Summary

If you did not enroll in an HMO plan, you and your dependents are covered by the indemnity medical benefits described below. More detailed explanations follow this summary.

<table>
<thead>
<tr>
<th>Benefits / Service</th>
<th>If You Use PPO Providers, Plan Pays</th>
<th>If You Use Non-PPO Providers, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Plan Features</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible (*waived for accidental injury for eligible expenses incurred within 90 days from the date of the accident)</td>
<td>$200 per person; $600 per family.</td>
<td>$200 per person; $600 per family. (does not include amounts in excess of usual, customary, and reasonable (UCR)).</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum (does not include deductibles or copays)</td>
<td>$2,000 per person; $6,000 per family.</td>
<td>$5,000 per person; $15,000 per family (does not include amounts in excess of usual, customary, and Reasonable (UCR)).</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$1,000,000 per person.</td>
<td>$1,000,000 per person.</td>
</tr>
<tr>
<td>How the Plan Works</td>
<td>Eligible expenses provided by PPO providers are paid at 80% until your out-of-pocket expenses (your 20% cost share) for coinsurance adds up to $2,000 per person or $6,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year.</td>
<td>Eligible expenses provided by non-PPO providers are paid at 60% until your out-of-pocket expenses (your 40% cost share) for coinsurance adds up to $5,000 per person or $15,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year.</td>
</tr>
</tbody>
</table>

## Hospital and Emergency Room Benefits

<table>
<thead>
<tr>
<th>Benefits / Service</th>
<th>If You Use PPO Providers, Plan Pays</th>
<th>If You Use Non-PPO Providers, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Care</td>
<td>You pay $100 co-pay per visit, then the Plan pays 80% PPO allowed amount after deductible if due to an illness. Co-pay waived for treatment of injury within 48 hours of covered accident or if admitted.</td>
<td>You pay $100 co-pay per visit, and then the Plan pays 60% of usual, customary, and reasonable (UCR) after deductible. Co-pay waived for treatment of injury within 48 hours of covered accident or if admitted.</td>
</tr>
<tr>
<td>BENEFITS / SERVICE</td>
<td>IF YOU USE PPO PROVIDERS, PLAN PAYS</td>
<td>IF YOU USE NON-PPO PROVIDERS, PLAN PAYS</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>80% of PPO allowed amount after deductible.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible.</td>
</tr>
<tr>
<td>Utilization Review Required for Hospitalization</td>
<td>If admission is not pre-authorized, inpatient hospital paid at 70% of PPO allowed amount after deductible prior to your out-of-pocket maximum being met, and 90% of PPO allowed amount after your out-of-pocket maximum has been met. The additional 10% difference due to not pre-authorizing is not applied to the out-of-pocket maximums.</td>
<td>If admission is not pre-authorized, inpatient hospital paid at 50% of usual, customary, and reasonable (UCR) after deductible prior to your out-of-pocket maximum being met, and 90% of usual, customary and reasonable (UCR) after your out-of-pocket maximum has been met. The additional 10% difference due to not pre-authorizing is not applied to the out-of-pocket maximums.</td>
</tr>
</tbody>
</table>

**PHYSICIAN SERVICES**

| Inpatient                                              | 80% of PPO allowed amount after deductible.                                                       | 60% of usual, customary, and reasonable (UCR) after deductible.                                     |
| Outpatient                                             | 80% of PPO allowed amount after deductible.                                                       | 60% of usual, customary, and reasonable (UCR) after deductible.                                     |
| Surgery                                                | 80% of PPO allowed amount after deductible.                                                       | 60% of usual, customary, and reasonable (UCR) after deductible.                                     |
| Preventive Care (routine outpatient physical exams, immunizations, and well-child care) | 80% of PPO allowed amount after deductible up to $500 per person per calendar year.               | 60% of usual, customary, and reasonable (UCR) after deductible up to $500 per person per calendar year. |
| Inpatient Well Newborn Care                            | 80% of PPO allowed amount after deductible for up to seven days following birth.                  | 60% of usual, customary, and reasonable (UCR) after deductible for up to seven days following birth. |

**ALTERNATIVE TREATMENT SETTINGS, INSTEAD OF HOSPITALIZATION**

<p>| Home Health Care                                       | 100% of the PPO allowed amount up to 130 visits per person per calendar year. Deductible waived for this | 100% of usual, customary, and reasonable (UCR) up to 130 visits per person per calendar year. Deductible waived for this |</p>
<table>
<thead>
<tr>
<th>BENEFITS / SERVICE</th>
<th>IF YOU USE PPO PROVIDERS, PLAN PAYS</th>
<th>IF YOU USE NON-PPO PROVIDERS, PLAN PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>service.</td>
<td>service.</td>
</tr>
<tr>
<td>Hospice</td>
<td>100% of the PPO allowed amount up to $5,000 for one period of care. Deductible waived for this service.</td>
<td>100% of usual, customary, and reasonable (UCR) up to $5,000 for one period of care. Deductible waived for this service.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% of PPO allowed amount after deductible, up to 120 days per calendar year.</td>
<td>60% of usual, customary, and reasonable (UCR) charges after deductible, up to 120 days per calendar year.</td>
</tr>
<tr>
<td><strong>OTHER PLAN BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab</td>
<td>80% of PPO allowed amount after deductible.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible.</td>
</tr>
<tr>
<td>In or Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% of PPO allowed amount after deductible.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible.</td>
</tr>
<tr>
<td>Spinal Manipulations (performed by a D.O. or D.C.)</td>
<td>80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
</tr>
<tr>
<td>Physical Therapy (must be a physician referral)</td>
<td>80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
</tr>
<tr>
<td>Occupational Therapy (must be a physician referral)</td>
<td>80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>80% of PPO allowed amount after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible.</td>
<td>80% of usual, customary, and reasonable (UCR) after deductible.</td>
</tr>
<tr>
<td>BENEFITS / SERVICE</td>
<td>IF YOU USE PPO PROVIDERS, PLAN PAYS</td>
<td>IF YOU USE NON-PPO PROVIDERS, PLAN PAYS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Massage Therapy (must be a physician referral)</td>
<td>80% of PPO allowed amount after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO maximum).</td>
</tr>
<tr>
<td>Jaw Treatment Benefit</td>
<td>80% of PPO allowed amount after deductible up to a $6,000 lifetime maximum combined PPO / Non-PPO for TMJ or MPD. Regular benefits apply to other jaw conditions and accidental injuries.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to a $6,000 lifetime maximum combined PPO / Non-PPO for TMJ or MPD. Regular benefits apply to other jaw conditions and accidental injuries.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>80% of PPO allowed amount after deductible up to $500 per ear ($1,000 maximum) combined PPO / Non-PPO. Replacement once in a three-year period.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to $500 per ear, ($1,000 maximum) combined PPO / Non-PPO. Replacement once in a three-year period.</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>80% of PPO allowed amount after deductible up to 60 treatments lifetime maximum combined PPO / Non-PPO.</td>
<td>60% of usual, customary, and reasonable (UCR) after deductible up to 60 treatments lifetime maximum combined PPO / Non-PPO.</td>
</tr>
</tbody>
</table>

Benefits for prescription drugs are covered in a separate program administered by Medco Health. Refer to pages 48 to 53 for a complete description of these benefits.

Benefits for mental health and chemical dependency are covered in a separate program administered by Health Management Concepts, Inc. Refer to pages 55 to 64 for a complete description of these benefits.

**Calendar Year Deductible**

You must generally pay a deductible each calendar year before the Plan pays benefits. The combined annual deductible for PPO and non-PPO providers is $200 per person of eligible expenses ($600 of eligible expenses per family). To satisfy your deductible, submit charges to your Area Administrative Office, which will apply all eligible expenses until the $200 has been reached.

**Deductible Carryover Provision** — The calendar year deductible must be satisfied by eligible expenses incurred in that year. Any eligible expenses incurred during the last three months of the previous calendar year and applied to that year’s deductible, will be carried over and also applied to the next year’s deductible. This carryover provision does not apply to out-of-pocket expenses.
**Accidental Injury** — The deductible will not apply to eligible expenses due to an accidental injury which are incurred within 90 days of the accident.

**COINSURANCE**

If you use a preferred provider, the Medical Plan will pay 80% of the doctor’s PPO contractual fee (allowed amount) for eligible expenses after the deductible. If you use a non-PPO provider, the Medical Plan will pay 60% of the usual, customary, and reasonable (UCR) fees for eligible expenses after the deductible.

**ANNUAL OUT-OF-POCKET MAXIMUM FOR COINSURANCE**

Annual out-of-pocket maximums for coinsurance are maintained separately for PPO and non-PPO providers. Eligible expenses provided by PPO providers are paid at 80% until your out-of-pocket eligible expenses (your 20% cost share) for coinsurance adds up to $2,000 per person or $6,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year. Eligible out-of-pocket expenses do not include deductibles, co-payments, reductions for not pre-authorizing, or other expenses not eligible for reimbursement under the Plan.

Eligible expenses provided by non-PPO providers are paid at 60% until your out-of-pocket expenses (your 40% cost share) for coinsurance adds up to $5,000 per person or $15,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year. Eligible out-of-pocket expenses do not include deductibles, co-payments, reductions for not pre-authorizing, amounts in excess of usual, customary, and reasonable (UCR) charges or other expenses not eligible for reimbursement under the Plan.

Eligible expenses by non-PPO providers for life threatening emergencies and/or life threatening accidental injuries are paid as if provided by a PPO provider.

Any additional coinsurance requirements for non-compliance with inpatient hospital pre-authorization requirements for either PPO or non-PPO providers do not apply to the out-of-pocket expense maximum.

**Hidden Providers**

In limited circumstances benefits for services provided by a non-PPO provider will be reimbursed at the PPO provider rate. These circumstances are:

- When you use a PPO facility and receive services from a non-PPO anesthesiologist, radiologist, emergency room physician, pathologist or laboratory, or in an emergency situation receive services from non-PPO staff or on-call physicians.
- You receive services from a PPO physician who in turn utilizes services from a non-PPO co-surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, or laboratory.

If benefits are paid at the PPO rate to a non-PPO provider under these provisions, the amount is counted toward the annual out-of-pocket maximum for PPO providers.
Out of Area Benefits

If you receive care from a non-PPO provider, the Plan pays most eligible expenses at 60% of the usual, customary, and reasonable (UCR) allowance. If you live over 30 miles from the nearest network provider or network facility that provides the medically necessary services you require, eligible expenses will be paid at 80% of usual, customary, and reasonable (UCR). Any charges in excess of the usual, customary, and reasonable (UCR) allowance are your responsibility.

Overall Medical Benefits Maximum

The overall medical benefits lifetime maximum for each eligible person is $1,000,000 whether paid in one year or over a period of years. Whenever medical benefits are paid, they are charged against the individual’s overall maximum. This is a cumulative total and applies to all benefits paid under any Trust indemnity medical plan.

Eligible Expenses

You and your eligible dependents are entitled to benefit payments for the medical services and supplies described on pages 32 to 36, if medically necessary for the treatment of sickness or injury and if ordered by a physician. Benefit payments are subject to all other Plan provisions including those relating to PPO providers, care management, definitions, and exclusions.

Inpatient Hospital Expenses

Hospital Charges for Standard Semi-Private Room and Board — Benefits are paid based on the applicable plan allowances of 80% for PPO and 60% for non-PPO.

Hospital Charges for Private Room — If necessary for isolation due to the patient’s communicable disease.

Other Hospital Services — Charges for other services and supplies furnished by the hospital such as operating room, medicines, drugs, anesthesia, x-ray examinations, treatment with radiation and other radioactive substances, laboratory tests, surgical dressings and supplies, but not professional services.

Covered Expenses In or Out of the Hospital

Acupuncture — Treatment by a licensed or registered acupuncturist. The Plan covers charges for medically necessary services to a maximum of 10 combined PPO/Non-PPO visits per calendar year.

Ambulance — Local professional licensed ambulance service, when medically necessary, to or from the nearest accredited hospital qualified to treat the condition. Air ambulance services are covered when medically necessary and only when other ambulance transportation would endanger life or safety. Ambulance services will be paid at the preferred level.
Anesthesia — Cost of anesthetics and their administration for treatment of a covered medical condition.

Blood transfusions — Including cost of blood and blood derivatives used by a covered patient and not replaced by a donor.

Dental Services — Charges for treatment by a doctor, dentist, or dental surgeon for removal of a malignant tumor or treatment of injuries to natural teeth (including replacement of such teeth and related x-rays) within 12 months after the accident. Coverage for care in an emergency room, hospital, or surgery center is not covered. Charges made for the treatment of deteriorating teeth and gums due to radiation therapy or chemotherapy, as long as such treatment is considered medically necessary. Such coverage is limited to a $10,000 lifetime maximum.

Dietary Formula — When medically necessary for the treatment of phenylketonuria (PKU).

Doctors Services — Covered surgery, home, office, or hospital visits and other medical care.

Durable Medical Equipment and Medical Supplies — Covered for artificial limbs, eyes, and larynx; surgical dressings; casts, splints, trusses, braces, crutches, and blood glucose monitors; rental of wheel chair, hospital bed, and respirator; and oxygen and rental of equipment for its administration. The rental cost of durable medical equipment is covered up to the purchase price.

Gastric Bypass and Obesity Surgery — Charges for vertical banded gastroplasty accompanied by gastric banding or gastric segmentation with a Roux-en-Y bypass are covered when approved by the Plan. The patient must be over 18 and meet the criteria used by the Plan to determine coverage which includes: body mass index above 40 for at least five consecutive years, participation for 12 months in a physician-supervised diet and exercise program, and the Trust’s medical review and approval. Pre-authorization is required.

Hearing Aids — Charges for a hearing examination and hearing aid devices up to $500 per ear with a maximum of $1,000 combined PPO/Non-PPO in any three-year period. You must be examined by a licensed physician or a licensed or certified audiologist. The examining physician must certify that the patient is suffering from hearing loss that may be lessened by use of the hearing aid.

Inpatient Well-Baby Care — Eligible inpatient hospital expenses for well newborns from birth up to seven days. For the child’s charges to be covered, the mother must also be hospitalized.

Jaw Treatment — Diagnosis and treatment, surgical and non-surgical, by a physician or dentist for Temporomandibular Joint (TMJ)/Myofascial Pain Dysfunction (MPD) and conditions which the Trust, upon medical review, determines are related to such jaw conditions, will be covered up to a $6,000 lifetime maximum combined PPO/Non-PPO. Regular Plan benefits apply to other jaw conditions, including treatment related to congenital skeletal deformities, tumors, or malignancies. Jaw treatment maximums do not apply to jaw surgery or repair if the required treatment is for accidental injury. Regular Plan benefits apply and require treatment to be started within the 12 months immediately following the accident unless you can show that it was not reasonably possible to begin treatment within the 12 months and treatment began as soon as reasonably possible. Orthodontia is not covered.
**Massage Therapy** — By a licensed, certified, or registered massage therapist. The Plan covers charges for medically necessary services to a maximum of 10 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

**Mastectomy Benefits** — Reconstruction of the breast after mastectomy, treatment of complications in all stages of mastectomy including lymphedemas, any prostheses required as a result of the mastectomy, and surgery and reconstruction on the non-diseased breast to make it equal in size with the reconstructed diseased breast.

**Nursing Care** — Private duty nursing by a registered nurse.

**Obstetrical Care — Hospital and Professional** — Pregnancy and childbirth are covered as any other condition for you or your spouse.

**Occupational Therapy** — By a licensed or registered occupational therapist. The Plan covers charges for medically necessary services to a maximum of 24 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

**Organ and Bone Marrow Transplants** — Human organ transplants considered medically necessary, appropriate, and effective using prevailing standards of community medical practice. Experimental transplants are not covered.

Medical expenses of the donor will be covered in absence of other group insurance. These expenses include testing for potential donors, and selecting and procuring the organ. If donor expenses are eligible under another plan, this Plan’s coordination of benefits provision will apply.

**Donor Costs**

Covered services include: selection, removal (harvesting), and evaluation of the donor organ, bone marrow, or stem cells; transportation of donor organ, bone marrow, and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and, storage costs for bone marrow and stem cells for a period of up to 12 months.

**Transportation, Meals, and Lodging Expenses Actually Incurred**

Reasonable and necessary expenses for travel, lodging, and meals for the transplant recipient (while not confined) and/or donor and one companion will be covered subject to the following limitations:

- The transplant recipient and/or donor must reside more than 50 miles from the approved transplant center.
- The travel must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
- When the recipient and/or donor is not a dependent minor child, transportation, covered lodging, and meal expenses for the recipient and/or donor and one companion will be reimbursed (receipts must be provided to the Trust).
• When the recipient and/or donor is a dependent child, transportation, covered lodging, and meal expenses for the recipient and/or donor and two companions will be reimbursed (receipts must be provided to the Trust).

• Covered transportation, lodging, and meal expenses incurred by the transplant recipient and/or donor and companion(s) are limited to $7,500 each per transplant.

These expenses must be reasonable for the services they relate to and require pre-authorization from the Trust’s utilization review program.

No Transplant Benefits Will Be Paid For:

• Non-human, artificial, or mechanical transplants;
• Recipients not covered under the Plan;
• Experimental or investigational procedures as determined by the Plan; or
• Donor and procurement costs incurred outside the United States unless pre-authorized by the Plan.

Orthotics — Impression casting, corrective shoes, and appliances are covered once every 24 months when medically necessary and prescribed by your attending physician. Orthotics prescribed for sports or recreational purposes are not covered.

Physical Therapy — By a licensed or registered physical therapist. The Plan covers charges for medically necessary services to a maximum of 24 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

Prostheses — Prostheses including artificial limbs, eyes, and larynx to replace natural body parts. Cosmetic or electronic prostheses are not covered. Prostheses will be replaced only if the original cannot be made functional.

Radiation and Chemotherapy Treatments — Includes treatment with radioactive substances.

Routine Mammography — Diagnostic and screening mammography recommended by your physician.

Routine Physical Exams — Routine physical exams, related lab work and x-rays, well-child care, and immunizations. Benefits are covered up to $500 per person per calendar year after deductible, combined PPO/Non-PPO.

Spinal Manipulations — By a Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) for up to 24 manipulations (combined PPO/Non-PPO providers) per calendar year. You or your doctor may be required to provide supportive materials such as x-rays, chart notes, and treatment plans. Treatment for patients under age 15 is subject to review.

Speech Therapy — If part of a prescribed treatment program, speech therapy by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by injury or sickness (except a mental, psychoneurotic, or personality disorder) or by surgery for that injury or sickness is covered up to 60 treatments per lifetime combined PPO/Non-PPO. Oral motor training is not considered medical treatment. Pre-authorization is recommended.
Care Management Programs

The Trust provides Care Management Programs to help you receive cost effective care and help the Trust control costs to ensure appropriate use of Trust resources. These programs apply to all Active employees, Casual employees, and their dependents who are covered by the Trust’s indemnity medical benefits. They do not apply to anyone covered by an HMO Plan. Your care management programs described on the following pages include:

- Preferred Provider Organization (PPO)
- Hospital Pre-authorization Program
- Hospital Discharge Planning and Case Management
- Skilled Nursing Facility
- Home Health Care
- Hospice Care

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) is available to most Trust participants and their covered dependents. The PPO helps the Trust offer health care at a lower cost. The PPO credentials and contracts with preferred providers offer a network of primary care physicians, specialists, hospitals, and clinics. The PPO also negotiates fees with these doctors and facilities and passes the savings on to you, so that you can obtain medical services from these providers at a favorable rate. Of course, you are not required to use PPO providers. You can use any eligible provider you wish.

When you use a PPO provider, your out-of-pocket expenses will be less than if you were treated by a non-PPO provider since you have a higher level of benefits and your benefits are based on discounted rates. You will be responsible for the deductible and coinsurance. The PPO will also handle your claim paperwork.

If you elect to use a non-PPO provider, the Trust will pay a percentage of usual, customary, and reasonable (UCR) charges in excess of the deductible. In addition to the deductible and coinsurance, you will be responsible for any amount over usual, customary, and reasonable (UCR).

PPO Directories

Provider directories are available from your Area Administrative Office. For the most up-to-date information, you can also check online at www.anthem.com/ca if you reside in California. If you live outside California, go to www.bluecares.com. Once you find this page, go to the “Blue Finder” tab, then click on “Doctor Finder.” You will then enter your information to find a network provider near you. Because PPO providers change, be sure to verify your provider’s participation before obtaining services. Being listed in the PPO directory does not guarantee the provider continues to participate in the PPO.
Also, please remember the Trust does not utilize Anthem for mental health or substance abuse treatment. These types of providers and Trust coverage are provided by HMC/APS. See the mental health and chemical dependency section beginning on page 55 for additional information on these benefits.

**Hospital Pre-authorization Program**

All non-emergency admissions, to PPO or non-PPO hospitals, must be pre-authorized before you or a covered dependent enters the hospital. A review determines the length of stay, based on the patient’s condition, which will be considered eligible for medical benefits. Each inpatient hospital admission is reviewed by the Utilization Review Company before the patient enters the hospital. If your hospital stay is not pre-authorized, benefits are paid at a reduced rate, as follows:

PPO hospital charges are paid at 70% of eligible expenses after deductible prior to your out-of-pocket maximum being met, and 90% of PPO allowed amount after your out-of-pocket maximum has been met if admission is not pre-authorized. The additional 10% difference due to not pre-authorizing is not applied to the out-of-pocket maximums.

Non-PPO hospital charges are paid at 50% of usual, customary and reasonable (UCR) expenses after deductible prior to your out-of-pocket maximum being met, and 90% of usual, customary and reasonable (UCR) expenses after your out-of-pocket maximum has been met. The additional 10% difference due to not pre-authorizing is not applied to the out-of-pocket maximums.

The phone number to call for pre-authorization is listed on the back of the member’s I.D. card (1-800-274-7767).

If the admission is an emergency, you must notify the Utilization Review Company within 48 hours after admission.

Admissions for childbirth are allowed for up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. The discharge may be earlier as long as the patient and provider agree.

Admissions for inpatient and alternative psychiatric or chemical dependency treatment must be authorized by HMC/APS. The contact number is 1-866-521-0086. See page 55 for information.

**Hospital Discharge Planning and Case Management**

Discharge planning helps in situations when you require continued medical care, but not necessarily inpatient hospitalization. The Utilization Review Company employs case management nurses who will work with you, your family, your physician, and the hospital staff to develop a plan that follows your release from the hospital. Your case manager also can arrange home health care, skilled nursing care, and hospice care.
Skilled Nursing Facility

The Plan covers skilled nursing facility care after you or a covered dependent have been hospitalized and have received benefits for at least three days. The care must be recommended by your doctor for the same condition which caused your hospitalization. Charges for custodial care, personal items, and private duty nursing are excluded. Benefits are payable for board and other services and supplies furnished by the facility for medically necessary care. The patient must be under continuous care of his or her doctor and require 24-hour nursing care.

Covered charges for the same or related conditions are covered up to a 120-day per calendar year maximum, combined PPO/Non-PPO.

Home Health Care

The Trust pays for eligible expenses provided as part of a home health care treatment plan to treat an illness or injury. Home health care benefits pay 100% of eligible expenses for services and supplies provided by a Home Health Care Agency, subject to the following conditions:

- The patient is under the care of a doctor who submits a written “home health care plan” for care and treatment in the patient’s home, and
- Services and supplies are furnished when, if it was not for home health care, inpatient confinement in a hospital, convalescent nursing home, or skilled nursing facility would be required.

The eligible expenses are the Home Health Care Agency’s charges for the following services and supplies ordered by the doctor under the home health care plan and furnished in the patient’s home:

- Part-time or intermittent nursing provided or supervised by a Registered Nurse (R.N.).
- Part-time or intermittent home health aide services, primarily for the patient’s care.
- Physical, occupational, speech, or respiratory therapy by a qualified therapist.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Medical supplies, laboratory services, drugs, and medications prescribed by a doctor.

The Trust pays for up to 130 home health care visits per person, in a calendar year PPO/Non-PPO combined. A visit by a representative of a home health care agency, other than a home health aide, constitutes one visit. For home health aides, each visit lasting four hours or less counts as one visit. If a visit exceeds four hours, each four hours or fraction of an hour counts as a separate visit.

The annual plan deductible is waived for home health care benefits. Coverage for Non-PPO providers is limited to usual, customary, and reasonable (UCR) charges.

Hospice Care

The Trust covers charges incurred by a terminally ill person in a hospice care program. Certification of terminal illness must be provided to the Area Administrative Office.
Benefits are paid if the hospice service or stay is:

- Provided while the terminally ill person is an eligible individual;
- Ordered by the attending physician as part of the hospice care program;
- Charged by the hospice care program; and
- Provided within six months of the terminally ill person’s entry or re-entry (after a remission period) in the hospice care program.

The lifetime maximum for hospice services for one period of care is $5,000 per person PPO and Non-PPO combined. The annual plan deductible is waived for Hospice Care benefits. Coverage for Non-PPO providers is limited to usual, customary, and reasonable (UCR) charges.

**Hospice Care Bereavement Benefits** — As part of Hospice Care, the Trust covers counseling services for the family of a terminally ill person, if ordered and received under the hospice care program.

Bereavement benefits for a Trust participant and his or her covered dependents will be paid if:

- The terminally ill person was in the hospice care program on the day prior to death.
- Requested by a covered family member.
- The charges are incurred within three months following the date the terminally ill person dies.
- Counseling is ordered and received through the hospice care program.

The maximum lifetime bereavement benefit per family is $200, PPO and Non-PPO combined.

**Indemnity Medical Benefit Exclusions**

Indemnity Medical benefits are not payable for any of the following items. This applies to all medical benefits described on pages 27 to 39.

1. Services or supplies subject to the General Exclusions applicable to all benefits. See pages 87 to 88.
2. Educational services or supplies. A charge for a service or supply is not covered to the extent that it is determined by the Trust’s medical consultants to be educational. For hospital stays, the length of stay and hospital services and supplies are not covered to the extent they are for education or vocational training of the patient.
3. Education, training, or services for treatment of dyslexia, attention deficit disorders, or delays in the development of a child’s language, cognitive, motor, or social skills.
4. Services related to vision: (a) exams to determine the need for (or changes of) eyeglasses or lenses of any type; (b) eyeglasses or lenses except initial replacements for loss of the natural lens; or (c) eye surgery (such as radial keratotomy or LASIK surgery) to correct myopia (near-sightedness), hyperopia (far-sightedness), or astigmatism (blurring). See pages 75 to 79 for a description of your vision plan.
5. Prescription drugs purchased from a retail pharmacy, mail order pharmacy, or hospital pharmacy. If a prescription drug is specifically excluded under the managed prescription drug program, and is determined to be medically necessary, it may be covered under the Medical Plan. See pages 48 to 53 for a description of your prescription drug benefits.
6. Vitamins, nutritional or dietary supplements, or over-the-counter drugs or medications (whether or not prescribed by a physician).
7. Orthopedic appliances, shoes, or orthotics prescribed primarily for use during participation in sports, recreational, or similar activities.
8. Mental health or chemical dependency. See pages 55 to 64 for a description of your mental health and chemical dependency benefits.
9. Diagnosis and treatment to restore fertility or promote conception such as: in-vitro-fertilization, artificial insemination or embryo-transfer procedures, microinjections, zona drilling, or other artificial means of conception, consecutive follicular ultrasounds, cycle therapy, and corresponding laboratory tests when associated with artificial means of conception (for a covered person or surrogate as a donor or a recipient).
10. Periodontal or dental disease or any condition involving the teeth, surrounding tissue or structure, or alveolar process of the gums. This includes, but is not limited to charges for doctor’s services, facility charges, and/or x-rays. This exclusion does not apply for charges made for the treatment of deteriorating teeth and gums due to radiation therapy or chemotherapy, as long as such treatment is considered medically necessary. Such coverage is limited to a $10,000 lifetime maximum.
11. Jaw surgery, orthodontic treatment for malocclusion or TMJ (except as described on page 33).
12. Hygienic or routine foot care such as treatment of: (a) weak, strained, flat, unstable, or unbalanced feet; (b) metatarsalgia or bunions (except open cutting operations); (c) corns, calluses, or trimming of nails, except removing nail roots; and (d) care prescribed by an MD or DO treating metabolic or peripheral-vascular disease.
13. Spinal manipulations in excess of 24 treatments per calendar year.
14. Physical therapy services ordered by a physician in excess of 24 treatments per calendar year.
15. Occupational therapy services ordered by a physician in excess of 24 treatments per calendar year.
16. Massage therapy services ordered by a physician in excess of 10 treatments per calendar year.
17. Acupuncture treatments in excess of 10 treatments per calendar year.
18. Pregnancy, or complications resulting from a pregnancy, of a covered dependent child including, but not limited to delivery, abortion, and miscarriage.
19. Expenses in connection with hearing aids, including: (a) a hearing examination without a device being obtained; (b) replacement of a hearing aid for any reason more than once in a three-year period; (c) batteries or ancillary equipment other than that obtained upon purchase of the hearing aid; (d) expenses an eligible person is not required to pay; or (e) repairs, servicing, or alterations of the hearing aid.
20. Long-term storage of blood other than charges associated with bone marrow transplants.
21. Charges, services, or supplies prescribed or provided by non-covered providers.
22. Any hospital confinement, medical, or surgical treatment to repair or treat a condition arising from a medical treatment or procedure not covered by this Plan.
23. Supplies which are not considered by the Trust to be durable medical equipment such as air purifiers, hot tubs, waterbeds, exercise equipment, ergonomic chairs, etc., (whether or not prescribed by a physician).
24. Services or supplies for your convenience or that of your family, or personal services such as meals for guests, telephone charges, television charges, or barber or beautician charges.
25. Routine office visits, lab tests, x-rays or immunizations in excess of $500 per person per calendar year.
26. Cosmetic surgery, including treatment of complications resulting from such surgery except for:
   - Accidental injuries as long as treatment occurs within 12 months of the injury.
- Reconstruction of a breast after mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed breast.
- Prostheses and treatment of physical complications of mastectomies including lymphedemas.

27. Learning disabilities, marital family problems (including counseling), sexual problems (including counseling), or eating disorders.
28. Education or training, including vocational assistance or counseling, rehabilitation, or job training or outreach, lifestyle, or fitness programs.
29. Expenses applied to satisfy the annual plan deductible.
30. Expenses in connection with conception, pregnancy, or delivery in connection with a surrogacy arrangement.
31. Sex transformations or complications resulting from such surgery and sexual dysfunction treatment, except for conditions of organic origin where cause is documented by the attending physician.
32. Surgical treatment of obesity unless authorized by the Trust according to Plan guidelines.
33. Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
34. Donor costs for a solid organ transplant or bone marrow or stem cell re-infusion that is not covered under this benefit, or for a recipient who is not a participant in this Trust.
35. Nonhuman or mechanical organs, unless it is determined they are not “Experimental/Investigational Services” according to accepted medical criteria.
36. Personal care items.
37. Anti-rejection drugs except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed. Take-home prescription drugs are covered under the Prescription Drug Benefit.
Indemnity Medical Benefits Definitions

Accidental Injury — Physical harm, which is sudden and traumatic in nature, caused by the intervention of an external force at a specific time and place. It is independent of illness except for infection of a cut or wound.

Acupuncture — Treatment of an injury, illness, or condition through the use of piercing specific areas of the body along peripheral nerves with fine needles to relieve pain and for therapeutic purposes. Services must be performed by a licensed acupuncturist or qualified licensed provider performing such services.

Area Administrative Office — The Administrative Offices retained by the Trust to provide administrative services. See page 118 for a list of Area Administrative Offices.

Calendar Year — Period of one year beginning January 1 and ending December 31.

Coinsurance — The percentage of the charge you are responsible for paying.

Cosmetic Surgery — Surgery performed to alter the texture or configuration of the skin, or any bodily feature’s configuration or relationship with adjoining structures. It is performed primarily for psychological purposes and does not correct or materially improve a bodily function or treat an illness or accident.

Custodial Care — Any portion of a service, procedure, or supply that, in the Trust’s judgment, is provided primarily:

- For ongoing maintenance of health and not for its therapeutic value in treating an illness or accidental injury.
- To assist the patient in meeting the activities of daily living such as help in walking, bathing, dressing, eating, preparation of special diets, and supervising self-administration of medications.
- To sustain a patient without attempting to treat an illness or injury.

Deductible — The amount of eligible medical expenses you must pay each calendar year before the Trust pays medical benefits.

Doctor or Provider — A licensed or certified practitioner of the healing arts acting within the scope of his or her license in the state in which services are being provided, including, but not limited to:

- Medical Doctors
- Chiropractors
- Naturopaths
- Physical Therapists
- Occupational Therapists
- Physician’s Assistants
- Registered Nurse Practitioners
- Massage Therapists
- Acupuncturists
- Midwives

Durable Medical Equipment — Medically necessary equipment that can stand repeated use (except certain consumable medical supplies):
• Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury.
• Ordered and/or prescribed by a physician for the exclusive use of the patient.
• The least costly alternative that can be safely provided.

Experimental and Investigational — Any service, (treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply) that meets one or more of the following criteria as determined by the Trust or its medical consultants:

• A drug or device that cannot be lawfully marketed without United States Food and Drug Administration (FDA) approval and has not been granted that approval on the date it is furnished.
• A facility or provider who has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases.
• Reliable evidence shows the service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
• Reliable evidence shows the service is not as safe and effective for a particular medical condition, as compared to other generally available services, and poses a significant risk to the patient’s health or safety.

Reliable evidence means published reports and articles in authoritative medical and scientific literature, scientific results of your provider’s written protocols or scientific data from another provider studying the same service.

Home Health Aide — A person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a home health care agency.

Home Health Care Agency — A hospital, agency, or other service certified to provide home health care by the proper authority of the state in which it is located.

Home Health Care Treatment Plan — A program of home care that is:

• Required as the result of sickness or injury.
• Established and reviewed at least every 60 days by the attending physician.
• Certified by the attending physician as a replacement for hospital confinement or confinement in a skilled nursing facility that would otherwise be necessary.

The treatment plan must also describe the medically necessary services and supplies to be provided by the approved home health care agency or approved providers of service. Treatment plans are subject to periodic review by your Utilization Review Company and your Area Administrative Office.

Hospice — A facility that provides short stays for a terminally ill person in a home-like setting for either direct care or respite care. This facility may be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program. If required by a state to be licensed, certified, or registered, the facility must also meet that requirement to be covered.
**Hospice Care Program** — A program directed by a doctor to help care for a terminally ill person. This may be through:

- A centrally-administered, medically-directed, and nurse-coordinated program that provides a system of home care, uses a hospice team, and is available 24 hours a day, seven days a week; or
- Confinement in a hospice.

The program must meet standards set by the National Hospice Organization and be approved by the Trust or its medical consultants. To be considered a hospice care program, the program must also meet any state requirements to be licensed, certified, or registered.

**Hospital** — A legally operated institution which:

- Is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- Is supervised by a staff of doctors with 24-hour nursing service and primarily provides:
  - General inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
  - Specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a qualified hospital or specialized provider of these facilities.

The term hospital does not include a nursing home or institution (or part of one) used primarily as a facility for convalescence, nursing, rest, the aged, treatment of chemical dependency, domiciliary, custodial care (including training in daily living routines), or is operated primarily as a school.

**Indemnity Medical Benefits** — The term Indemnity Medical benefits refers to the benefits provided that are medical in nature and provided by medical practitioners. It does not include prescription, mental health or substance abuse treatment, which are part of the health and welfare plan for Active Regular Employees. In addition, it does not include any charges for services by a HMO provider if you have elected HMO coverage under the Trust.

**Life Threatening** — An illness, injury, or condition that, in the absence of immediate medical attention, could result in the patient’s death.

**Massage Therapy** — Treatment of an illness, injury, or condition through massage or similar treatments when performed by a massage therapist and prescribed by your physician or surgeon.

**Medical Consultant** — A qualified medical professional retained by the Trust to give medical advice for determining covered services and supplies, medical necessity, and usual, customary, and reasonable (UCR) allowances.

**Medically Necessary/Medical Necessity** — Treatments, services, or supplies that must be ordered through a physician or other qualified provider, and are commonly and customarily recognized by the physician’s profession as appropriate to treat the patient’s diagnosed injury or sickness (as specified by authoritative medical or scientific literature). This must be the least costly of alternative treatments, services, or supplies that can be safely provided. It does not
include maintenance or supportive treatments or services, or those that are educational, experimental, or primarily for medical or other research. The fact that any treatments, services, or supplies are furnished, prescribed, or approved by a physician or other qualified provider does not in itself mean it is medically necessary. A medical treatment, service, supply, or setting may be medically necessary in part only.

**Network or Preferred Provider** — A provider who has contracted with the Trust’s Preferred Provider Organization (PPO). See page 36 for a description of your PPO network.

**Non-Network or Non-Preferred Provider** — A provider who has not contracted with the Trust’s PPO Program. See page 36 for a description of your PPO network.

**Nurse** — Includes Licensed Registered Nurses (RN’s), Licensed Practical Nurses (LPN’s), Certified Nurse Practitioners (CRN’s), and Associate Registered Nurse Practitioners (ARNP’s).

**Occupational Therapy** — Rehabilitative treatment of an illness, injury, or condition when performed by a certified, registered, or licensed occupational therapist and prescribed by your physician or surgeon.

**Out-of-Pocket Maximum** — The annual limit on your portion of eligible expenses. The out-of-pocket maximum does not include deductibles, co-payments, reductions for not pre-authorizing, expenses not eligible for reimbursement under the plan, amounts over usual, customary, and reasonable (UCR) allowances or otherwise eligible expenses not covered by the Indemnity Medical Plan.

**Outpatient Care** — Treatment in a non-hospital facility or by a hospital for less than 23 hours with no room and board charges.

**Outpatient Surgical Center** — A physician’s office, medical clinic, or legally-operated institution engaged primarily in providing outpatient surgical services at the patient’s expense, which meets all established standards for this kind of facility.

**Physical Therapy** — Treatment of an illness, injury, or condition by physical means, such as massage, hydrotherapy, heat, or similar treatments when performed by a licensed or registered physical therapist and prescribed by your physician or surgeon.

**Physician Visit** — A personal interview where the physician sees the patient. Telephone consultations are not considered visits.

**PPO Allowed Amount** — A discounted or set negotiated rate for PPO services by a provider. The PPO provider cannot charge the patient more for any service than the PPO allowed amount.

**Preferred Provider Organization (PPO)** — A network of doctors, hospitals, and other health care providers who are members of the contracted PPO. These providers furnish medical services to Trust participants at negotiated rates.

**Pregnancy** — Pregnancy, including resulting childbirth, abortion, or miscarriage, shall be treated as a sickness for employees and dependent wives. Expenses in connection with the pregnancy of a dependent child are not covered.
**Remission** — A halt in the progression of a terminal disease, or reduction in the extent that the disease has progressed.

**Skilled Nursing Facility** — A licensed facility having seven or more beds, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and primarily for convalescent care. It must be under the supervision of a physician and surgeon and not a home for the care of mental health/chemical dependency patients or the aged, or a rest home or place for custodial care. This includes a facility that would be classified as a skilled nursing care facility under Medicare if the facility actively sought Medicare approval.

**Temporomandibular Joint Dysfunction (TMJ) and Myofascial Pain Disorder (MPD)** — A disorder of the temporomandibular joint (the joint that connects the mandible or jawbone to the temporal bone) generally characterized by:

- Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, or shoulders.
- Popping or clicking of the jaw.
- Limited jaw movement or locking of the jaw.
- Malocclusion, overbite or under-bite, and/or mastication difficulties.

**Terminally Ill Person** — A person whose life expectancy is six months or less, as certified by the primary attending doctor.

**Totally Disabled** — A person is considered totally disabled when, because of an accident or illness (including pregnancy and its complications), he or she is:

- Unable to perform the normal duties of his or her occupation.
- Not engaged in any occupation for wage or profit.
- Under a physician’s regular care for that injury or sickness.

A dependent is considered Totally Disabled when because of disability he or she is unable to engage in the normal activities of a person of the same age and gender.

**Usual, Customary, and Reasonable (UCR) Charges** — The maximum amount the Trust will consider for reimbursement. The amount is determined by comparing the actual charge for the services or supplies with the prevailing charges usually made by the provider when there is no health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust Preferred Provider Organization or other consultants will determine the prevailing charge.
Indemnity Medical Plan Prescription Drug Benefits — Actives and Casuals

This section explains the retail and mail order prescription drug benefits available to Active and Casual Plan participants and their covered dependents. These benefits do not apply if you have selected an HMO medical plan. These prescription benefits are not available if you are under the Catastrophic Needs Medical Plan.

The Trust’s retail and mail-order prescription drug benefits are administered by Medco Health.
Indemnity Prescription Drug Benefits for You and Your Covered Dependents

INTRODUCTION

The Trust has chosen Medco Health to manage your prescription drug benefit. If you and your covered dependents are enrolled for indemnity medical benefits, then your prescription drug benefits are administered by Medco Health. If you are enrolled in an HMO medical plan, your prescription drug coverage will be provided by the HMO. Medco Health is the Trust’s pharmacy benefit manager with a network of independent and chain pharmacy locations throughout the United States. These benefits are not available if you are under the Catastrophic Needs Medical Plan.

Only prescriptions purchased at Medco Health network pharmacies are covered by the Trust. If you go to a retail pharmacy that is not part of the Medco Health network, you are responsible for the full cost of the prescription.

PLAN BENEFITS

<table>
<thead>
<tr>
<th>RETAIL PHARMACY SERVICE</th>
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<tr>
<td>There is no annual deductible for retail prescriptions. You must, however, use a participating pharmacy. The percentage of the drug’s cost that you are responsible for is called coinsurance.</td>
</tr>
<tr>
<td>Generic drugs</td>
</tr>
<tr>
<td>Brand-name drugs</td>
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<tr>
<td>A maximum of up to a 34-day supply of covered medication is allowed.</td>
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For example, if a brand-name drug costs $150, the 20% coinsurance is $30 and your co-pay is $30. If a brand-name drug costs $50, the 20% coinsurance is $10 but your co-pay will be $25, the minimum required amount. For a generic drug, if your generic drug cost $75, the 20% coinsurance is $15 and your co-pay is $15. If a generic drug cost $25, the 20% coinsurance is $5 but your co-pay will be $10, the minimum required amount.

Qualified generic drugs will be substituted when permitted by the prescribing physician. If you demand a brand-name drug when your physician allows a qualified generic, you will pay the difference in cost between the brand and the generic, in addition to your cost share.
HOUSE DELIVERY PHARMACY SERVICE

There is no annual deductible for mail-order prescriptions.

| Generic drugs | You pay $0 co-pay per prescription |
| Brand-name drugs | You pay $50 co-pay per prescription |

A maximum of up to a 100-day supply of covered medication is allowed. Standard shipping and handling is free.

Formulary

Your prescription drug benefit includes a formulary, which is a list of generic and brand-name drugs that are preferred by the Trust. This list includes a wide selection of medications and is preferred because it offers you choice while helping to keep the cost of your prescription drug benefit affordable. The medications on the formulary have been selected by an independent group of doctors and pharmacists for safety and efficacy, and only Food and Drug Administration (FDA) approved medications are included. Medco Health may remind your doctor when a formulary medication is available instead of a medication that you are currently taking that is a non-formulary drug. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

A copy of the formulary is available from your Area Administrative Office; or visit www.medco.com or call Medco Health at 800-711-0927.

Generic Prescription Drugs

Generic drugs may differ in color, size, or shape, but the Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have lower co-pays. Therefore, you can get the same health benefits at a lower cost. You should ask your doctor or pharmacist whether a generic version of your medication is available and whether it would be right for you. By using a generic drug, you may be able to receive the same high-quality medication, but reduce your out-of-pocket expenses.

Qualified generic drugs will be substituted when permitted by the prescribing physician. If you demand a brand-name drug when your physician allows a qualified generic, you will pay the difference in cost between the brand and the generic, in addition to your cost share.

HOW RETAIL PHARMACY SERVICE WORKS

The retail pharmacy service is most convenient for filling your short-term prescription needs. You must use a Medco participating pharmacy to receive Trust benefits. For example, if you need an antibiotic to treat an infection, you can go to one of the many network pharmacies. To find out whether a pharmacy participates in the Medco Health network:
• Ask your retail pharmacist.
• Visit www.medco.com and use the online pharmacy locator.
• Call 800-711-0927 (800-759-1089 TTY) and use the interactive pharmacy locator.

**Ordering new prescriptions or refills at a network retail pharmacy:**

• Show your prescription ID card at the pharmacy or provide the social security number of the WTWT employee.
• Pay your coinsurance or co-pay (the pharmacist will tell you the amount).

**At non-network pharmacies:**

If you go to a retail pharmacy that is not part of the Medco Health network, you will not receive benefits from the Trust.

**HOW HOME DELIVERY PHARMACY SERVICE WORKS**

If you need medication on an ongoing basis, such as to treat asthma or diabetes, you can ask your doctor to prescribe up to a 100-day supply for home delivery, plus refills for up to one year (as appropriate). You will pay just one co-pay for each prescription or refill. Since you can get a larger supply of medication through the Home Delivery Pharmacy Service than at a participating retail pharmacy, you may save money.

With the Home Delivery Pharmacy Service:

• Your medications are dispensed by one of the pharmacists in Medco Health’s network of home delivery pharmacies.
• Medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an added charge).
• You can track your prescriptions online at www.medco.com, or by calling 800-711-0927 (800-759-1089 TTY).
• Registered pharmacists are available around-the-clock for medication consultations.

**Using Home Delivery Pharmacy Service for the First Time**

**Ask your doctor to write a new prescription** for up to a 100-day supply, plus refills for up to one year (if appropriate). Prescriptions may be submitted:

• **By mail** — Send the new prescription(s), along with a Medco Health Home Delivery Pharmacy Service Order Form and the appropriate co-pay, to Medco Health in the return envelope. You can print an order form from the www.medco.com website.
• **By fax** — Ask your doctor to call 888-327-9791 for instructions on how to fax a prescription. Only your doctor may fax a prescription. Be sure to give your doctor your Member ID number. You will be billed later.
• **Online** — Visit www.medco.com. Once you are registered and logged in, scroll to the bottom of the “order center,” click on the “request a new prescription from your doctor” link, and follow the on-screen instructions.
Your medication will be delivered within seven to 11 days after you mail your order. When placing your order, you should have at least a 14-day supply of medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply to be filled at your local participating retail pharmacy.

You can request additional Home Delivery Pharmacy Service Order Forms and envelopes at www.medco.com, or by calling 800-711-0927.

Refilling Your Prescription

You can refill your home delivery prescriptions online, by telephone, or by mail. Have your Member ID number and your prescription number for the medication. If you choose to pay by credit card, please have that number available as well.

- **Online** — Each time registered users log in to www.medco.com, available prescription refills will be displayed in the personalized “order center,” as well as within your prescription history. From the order center, simply check the box next to the items you want to order and follow the on-screen instructions to check out.
- **By telephone** — Call 800-473-3455 to use the automated refill system.
- **By mail** — Use the refill order form that will accompany your prescription. Mail it along with your co-pay to Medco Health in the return envelope.

To make sure that you don’t run out of your medication, remember to reorder 14 days before your medication runs out. You can find the refill date on your prescription bottle, on the refill slip that comes with every order, or at www.medco.com.

Paying for Your Medication

You may pay your portion of the cost by check, money order, or credit or debit card.

Covered Prescriptions

The following drugs, medicines and supplies are covered when prescribed by a physician, dentist, osteopath, or podiatrist within the scope of his or her license:

- Legend drugs requiring a prescription (any medicine labeled “Caution: federal law prohibits dispensing without a prescription”).
- Some drugs or medicines available without a prescription, including the following “over the counter” (OTC) medications: dental fluoride products, antacids, elixir terpin hydrate, epinephrine, ephedrine, ferrous sulfate/fumarate (selected products), and cough medications.
- Diabetic supplies including insulin, syringes, needles, test tapes or strips, acetone test tablets, Benedict’s solution or equivalent, lancets, or similar test supplies.
- Oral, transdermal, intravaginal, and injectable contraceptives (but not contraceptive devices such as diaphragms or cervical caps).
- Myeloid stimulants.
- Erectile dysfunction medications for males over age 18. These prescriptions are subject to quantity limitations of:
  - Retail pharmacy — 12 tablets per rolling 34 calendar days.
- Home delivery — 40 tablets per rolling 100 calendar days.

- Pediatric fluoride vitamins.

- Cosmetic dermatologicals such as Retin-A/Avita and Tazorac cream through age 34.

In addition, some prescription drugs require pre-authorization by the Trust. Examples are drugs used to treat rheumatoid arthritis, medical Botox, and Myobloc.

**Prescription Drug Benefit Exclusions**

The prescription drug benefit program *does not cover* the following:

1. More than a 34-day supply of medication for retail pharmacy prescriptions or an 100-day supply for home delivery service.
2. Services or supplies (including drugs) subject to the General Exclusions applicable to all benefits. See pages 87 to 88.
3. Drugs or medicines procured or procurable without a physician’s prescription, including all over-the-counter drugs, (except as described in Covered Prescriptions on Page 51).
4. Drugs to treat conditions, including experimental uses that are not within uses approved by the FDA or the manufacturer.
5. Medications, drugs, or supplies that are compensated for or furnished by any workers’ compensation, occupational disease law, or state or governmental agency.
6. Any prescription or refill that individually, or cumulatively over time, exceeds dosages approved by the Food and Drug Administration (FDA) or manufacturer recommendations.
7. Drugs dispensed in a hospital, nursing home, clinic, ambulatory surgical center, physician’s office, or other institution.
8. Drugs prescribed or purchased after coverage terminates.
9. Devices used to administer drugs (except as described in Covered Prescription Drugs).
10. Drugs labeled “Caution - limited by federal law to investigational use,” or experimental drugs.
11. Charges for the administration or injection of any drug.
12. Contraceptive jellies, creams, foams, or implant devices.
13. Biologics, immunization agents, or vaccines.
14. Therapeutic devices or appliances (canes, crutches, walkers, etc.).
15. Blood glucose monitors and glucowatch/sensors (may be covered under Plan’s medical benefits).
17. Drugs used to restore fertility or promote conception.
18. Blood or blood plasma products.
19. Any non-drug item, proprietary medicines, allergy sera, dietary supplements, vitamins (except pediatric fluoride vitamins), or health and beauty aids.
20. Prescriptions refilled above the number of refills specified by the physician or any refill dispensed after one year from the physician’s original order.
21. Injectable chemotherapy drugs (may be covered under the Plan’s medical benefits).
22. Smoking cessation products.
23. Cosmetic purpose drugs such as Minoxidil or Botox.
24. Substance abuse treatment drugs such as Methadone, Antabuse, Rexia, Subutex, or Suboxone.
Coordination of Benefits

Benefits for prescription drugs are not coordinated with other plans. The Trust will not provide benefits if benefits have been provided for a prescription under another plan.
Indemnity Medical Plan Mental Health and Chemical Dependency Benefits – Active, Casual and Catastrophic Needs Medical Plans

This section explains the mental health and chemical dependency benefits available to Active, Casual and Catastrophic Needs Medical Plan participants and their covered dependents. These benefits do not apply if you have selected an HMO medical plan.

The Trust’s mental health and chemical dependency benefits are provided and administered by Health Management Concepts, Inc. (HMC) and APS Healthcare.
Indemnity Mental Health and Chemical Dependency Benefits for You and Your Covered Dependents

THE PROGRAM AND HOW IT WORKS

HMC Companies (HMC) and APS Healthcare (APS) will administer the Trust’s indemnity plan’s mental health and chemical dependency benefits to provide a 24-hour employee assistance program, a panel of network providers, and other services related to your mental health and chemical dependency benefits. It applies to all participants in the Trust’s self-funded indemnity plan, except for Medicare-eligible retirees. It also does not apply to you if you are in an optional HMO plan. It will allow you to speak with clinical professionals about your personal and work-related issues, and to have them coordinate appropriate treatment for you. To receive benefits you must contact the Employee Member Assistance Program E/MAP before receiving services or treatment for mental health or chemical dependency. If you do not contact E/MAP before receiving treatment, you will not be eligible for benefits. E/MAP and its clinical professionals can be contacted at 1-866-521-0086.

In addition to directing participants to appropriate providers, E/MAP can provide up to five counseling sessions with an E/MAP counselor at no cost. Appointments are scheduled with providers convenient to your work or home and can be scheduled before or after work and on Saturdays.

You Must Contact E/MAP before Receiving Treatment

To receive benefits you must contact E/MAP before receiving services or treatment for mental health or chemical dependency issues. If you do not contact E/MAP before receiving treatment, you will not be eligible for benefits. E/MAP and its clinical professionals can be contacted at 1-866-521-0086.

Accessing Preferred Providers

Additionally, as before, the E/MAP program provides a network of participating providers. Many of the providers that participate in the previous network used by the Trust will also participate in the E/MAP network. You receive greater benefits if you use an E/MAP provider. To determine if a particular provider participates in the E/MAP network, you should contact E/MAP at 1-866-521-0086. Providers can also be located online at www.APSHelpLink.com (enter company code: WTWT). If you or your dependents have seen a mental health or chemical dependency practitioner in the past and you would like E/MAP to reach out to that practitioner for inclusion in the network, please call 1-866-521-0086.

Special Provision Where E/MAP Network Is Not Available

The E/MAP nationwide network of contracted providers and facilities can be expanded if a need for services in a particular location arises. Should you or a dependent need care, and E/MAP is unable to refer you to a network provider or facility provider located in your area (within a 30-minute driving distance or 20-mile radius from your home), you may use the services of a non-
E/MAP network provider or facility provider, and benefits will be paid as if a network provider or facility had been used, provided the treatment has been pre-authorized by E/MAP.

This applies only if you call E/MAP first and give E/MAP an opportunity to refer you to a network provider or facility in your area, or a provider or facility in your area willing to become a network member for the services that you or your dependent may require. Special situations must be reviewed and approved in advance by E/MAP.

**Emergency Services**

Coverage for inpatient hospitalization or alternate care treatment is conditioned on pre-notification and pre-authorization by E/MAP, except in cases of emergency. In an emergency, E/MAP will pay for covered services provided by the involved facility for the first 48 hours following the emergency admission.

Coverage for treatment provided after the 48 hours for emergency admission requires immediate notification to E/MAP and continuing authorization by E/MAP of all treatment.

To receive reimbursement for emergency treatment by a non-E/MAP network facility you must send copies of the emergency report, itemized bill, and your payment receipts to the E/MAP claims department.

**Out-of-Pocket Expenses**

Co-payments and other out-of-pocket expenses incurred under this program do not apply to deductibles or other out-of-pocket maximums under any of the Trust’s indemnity medical programs.
## Schedule of Benefits

<table>
<thead>
<tr>
<th></th>
<th>HMC/APS PROVIDER/FACILITY</th>
<th>NON-NETWORK PROVIDER/FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol or Drug Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan maximums include combined in and out-of-network treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Plan Benefits</td>
<td>Plan pays 90% up to $12,500 maximum per episode, after $150 deductible per episode.</td>
<td>Plan pays 50% of allowed charges up to $12,500 maximum per episode, after $500 deductible per episode.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>30 days maximum inpatient treatment (including de-tox), per episode, up to $12,500 maximum per episode.</td>
<td></td>
</tr>
<tr>
<td>Alternate Care: Residential Treatment</td>
<td>2 days of residential treatment equal 1 day of inpatient treatment.</td>
<td>Non-network inpatient treatment is limited to 30 inpatient days per year in combination with network treatment. Non-network residential, partial, and intensive outpatient treatment(s) are counted as regular inpatient days towards the annual limit.</td>
</tr>
<tr>
<td>Partial Treatment</td>
<td>2 days of partial treatment equal 1 day of inpatient treatment.</td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>3 days of intensive outpatient treatment equal 1 day of inpatient treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Combined network and non-network inpatient, residential treatment, partial treatment, and intensive outpatient treatment limited to equivalent of a maximum of 30 Inpatient Chemical Dependency treatment days per episode of treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An episode is defined as any continuous course of treatment that focuses on a particular occurrence of a chemical dependency problem. An episode may involve various levels of care or treatment using one or more providers or facilities as a part of medically necessary and clinically appropriate treatment of the presenting problem. Treatment of a relapse of the treated condition within 60 days is considered the same episode.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime maximum: 2 episodes per individual (including de-tox).</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Professional (SAP) Services</td>
<td>Provided to eligible active employee participants that fail DOT Alcohol or drug tests, including employees participating in HMO options through the Trust.</td>
<td>No Substance Abuse Professional (SAP) Services.</td>
</tr>
</tbody>
</table>

## Mental Health Plan Maximums Include Combined in and Out-of-Network Treatment

<p>| Assessment | Up to 3 individual assessment sessions per individual per calendar year. | No Individual Assessment Benefit. Covered under Outpatient Benefit. |</p>
<table>
<thead>
<tr>
<th></th>
<th><strong>HMC/APS PROVIDER/FACILITY</strong></th>
<th><strong>NON-NETWORK PROVIDER/FACILITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td>Plan pays up to 50 authorized combined individual/group sessions per individual per calendar year combined in and out-of-network.</td>
<td>Plan pays 50% of allowed charges up to 50 individual/group sessions per individual per calendar year combined in and out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Individual Sessions [You pay:] $0 visits 1 – 5 ]$10 visits 6 – 10 ]$20 visits 11 – 15 ]$30 visits 16 – 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group Sessions – $0</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Inpatient Benefits</strong></td>
<td>Plan pays 100% of authorized inpatient treatment up to 45 days per individual per calendar year.</td>
<td>Plan pays 50% of the allowed charges up to 45 days per individual per calendar year.</td>
</tr>
<tr>
<td><strong>Alternate Care:</strong></td>
<td><strong>Residential Treatment</strong> 2 days of residential treatment equal 1 day of inpatient treatment.</td>
<td>Non-network inpatient treatment is limited to 45 inpatient days per year in combination with network treatment. Non-network residential, partial, and intensive outpatient treatment(s) are counted as regular inpatient days towards the annual limit.</td>
</tr>
<tr>
<td></td>
<td><strong>Partial Treatment</strong> 2 days of partial treatment equal 1 day of inpatient treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Intensive Outpatient Treatment</strong> 3 days of intensive outpatient treatment equal 1 day of inpatient treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Combined network and non-network inpatient, residential treatment, partial treatment, and intensive outpatient treatment limited to equivalent of a maximum of 45 Inpatient Mental Health treatment days per calendar year and total lifetime maximum equivalent of 90 Inpatient Mental Health treatment days.</td>
<td></td>
</tr>
</tbody>
</table>
MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT EXCLUSIONS

Mental health and chemical dependency benefits are not payable for any of the following items:

1. Services supplied subject to the general exclusions applicable to all benefits. See pages 87 to 88.
2. Treatment of detoxification in newborns (treatment may be provided by the Trust’s medical plan).
3. Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease and Alzheimer’s disease.
4. Treatment of mental retardation, other than the initial diagnosis.
5. Treatment of obesity.
6. Court-ordered testing and treatment if not medically necessary.
7. Private hospital rooms and/or private duty nursing, unless medically necessary and authorized by HMC/APS.
8. Ancillary services, including vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or educational therapy for learning disabilities, or other educational services.
9. All in-network outpatient, inpatient, and alternate care services in excess of those authorized by HMC/APS.
10. Broken appointments, except when the participating provider is notified at least 24 hours in advance or in circumstances in which you had no control over missing the appointment and could not notify the participating provider in advance. You may be billed $30 for each broken appointment. A broken appointment counts as one session.
11. Prescription or non-prescription drugs, except for drugs prescribed by a physician in connection with treatment as an inpatient at a hospital, or as a patient at an alternate care treatment facility. See Prescription Drug Benefits on pages 48 to 53.
12. Inpatient services, treatment, or supplies provided without pre-admission certification from HMC/APS, except in an emergency.
13. Damage to the facility of a participating provider or facility provider caused by you or your dependent. The actual cost may be billed to you or your dependent.
14. Services, treatment, or supplies determined to be experimental by the HMC/APS Medical Director according to accepted mental health standards.
15. Health care services, treatment or supplies:
   - Provided by workers’ compensation law or similar legislation.
   - Obtained through, or required by, any governmental agency or program.
   - Caused by the conduct or omission of a third party for which you or your dependent has a claim for damages or relief.
16. Services, treatment, or supplies for military service disabilities, when treatment is available under governmental health care programs.
17. Supplies, treatment, or supplies primarily for rest, custodial, domiciliary, or convalescent care.
MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT DEFINITIONS

Allowable Charges — Fee or charge made by the provider of mental health or chemical dependency services, which may not exceed the prevailing charge in the area for a service of the same nature and duration.

Alternate Care Treatment — A planned, medical therapeutic program for patients with mental disorders or chemical dependency problems which includes diagnosis, medical care, and treatment when the patient does not require full-time hospitalization, but does need more intensive care than traditional outpatient visits.

Authorized Representative (AR) — A third party designated by you who can initiate reviews and appeals and follow through with respect to all related correspondence in order to process a claim under this program. An AR may include, but is not limited to a provider or a guardian. An AR must have legal documents or an assignment of benefits form designating him or her as an AR.

Authorization — A written decision, from the HMC/APS Medical Director or his/her designee, that benefits you or your eligible dependent may receive under this program are payable for certain services.

Chemical Dependency — Psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Coordination of Benefits — The coordination of benefits payment between two or more payers, on a primary or secondary basis, to avoid duplication of payments.

Co-payment — Fee to be collected directly by the HMC/APS network provider or facility from you or your eligible dependent for covered service. The co-payment is collected at the time the service is received or as agreed on by you and the HMC/APS network provider or facility.

Covered Services — See “Mental Health and Chemical Dependency Services.”

Custodial Care — Care rendered to a patient who:

1. Is mentally or physically disabled and the disability is expected to continue and be prolonged;
2. Requires a protected, monitored, or controlled environment whether in an institution or in a home;
3. Requires assistance to support the essentials of daily living; and
4. Is not under active and specific psychiatric treatment that will reduce the disability enough to enable the patient to function outside the protected, monitored, or controlled environment.

A determination that custodial care is required is not precluded by the fact that a patient is under the care of a physician or other provider and services are being ordered to support and maintain the patient’s condition, provide for the patient’s comfort, or ensure the manageability of the patient.
**Dependent** — Any person who is a “dependent” of an eligible participant according to the eligibility requirements of the Trust. See page 5.

**Domiciliary Care** — Inpatient institutional care provided, not because it is medically necessary, but because the care in the home setting is unavailable, unsuitable, or members of the patient’s family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

**Eligible Participant** — A participant who is eligible for the Trust indemnity medical benefits and is not enrolled in an HMO Plan.

**Emergency** — The sudden onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention and/or mental health and chemical dependency care services, could reasonably result in:

1. Serious injury to life or limb;
2. Permanently placing your health in jeopardy; or
3. Causing you serious and permanent dysfunction.

**Experimental** — Medical care that is investigatory or an unproven procedure or treatment that does not meet generally accepted standards of usual professional medical practice in the general medical community.

**Hospital** — Any licensed and accredited acute care psychiatric facility or psychiatric unit in a general acute care hospital that provides inpatient care, facilities, and services for the diagnosis and treatment of mental disorders.

**Inpatient** — An eligible participant or dependent who has been admitted to a hospital or alternate care program for bed occupancy to receive necessary mental health or chemical dependency services, with the reasonable expectation that the patient will remain in the institution at least 24 hours.

**Medical Director** — A physician employed by HMC/APS to coordinate and monitor the quality assurance, utilization management, provider, and facility service responsibilities for HMC/APS.

**Medically Necessary Service** (also “Medically Necessary” or “Medical Necessity”) — A health care service, treatment, or supply that meets the following conditions:

1. Provides for the treatment or diagnosis of a mental disorder or chemical dependency.
2. It is “appropriate,” that is:
   - Consistent given the symptoms and the diagnosis.
   - Type, level, and length of service, supply, and setting are needed to provide safe, adequate care, and treatment.
   - In keeping with the generally accepted standards for good medical practice within the organized medical community.
   - For a hospital stay, inpatient acute care must be required for treatment or diagnosis and safe, adequate care cannot be received on an outpatient basis or in a less restrictive setting.
- When provided by a professional, the professional is licensed or certified according to state and federal law, and the care, treatment, or supply is within the professional’s scope of practice as provided by state and federal law and the rules and regulations of supervising professional organization.

3. Not for the convenience of your eligible dependent, your health care provider, or HMC/APS.

4. Provided in an environment where mental health or chemical dependency services are performed at the least restrictive level of care that provides effective treatment.

5. Determined to be a medically necessary service by the HMC/APS Quality Assurance/Utilization Management Program.

**Mental Disorder** — A mental or nervous condition that meets the following conditions:

1. Clinically significant behavioral or psychological syndrome or pattern;
2. Associated with a painful symptom such as distress;
3. Impairs a patient’s ability to function in one or more major life activities; and
4. Listed as an Axis I Disorder (except for V-codes) of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) by the American Psychiatric Association (DSM-IV).

**Mental Health and Chemical Dependency Services** — Services that are medically necessary and clinically appropriate for the treatment of a mental disorder or chemical dependency. Services must be furnished by a professional provider and may include: outpatient individual and group therapy sessions, inpatient hospitalization, day treatment programs, evening programs, and intensive outpatient treatment.

**Network Facility** — An HMC/APS contracted hospital or approved alternate care program certified by state and federal laws which provides mental health or chemical dependency services to eligible participants and dependents. Network facility providers sign an agreement with HMC/APS to accept specific compensation as the total charge, whether paid by HMC/APS or requiring cost-sharing with the eligible participant.

**Network Provider** — A professional mental health care provider (such as licensed clinical social worker, psychologist, or psychiatrist) who furnishes mental health or chemical dependency services to eligible participants and dependents. Network providers sign an agreement with HMC/APS to accept specific compensation as the total charge, whether paid by HMC/APS or requiring cost-sharing with the eligible participant.

**Other Plan or Plan** — Any plan which provides full or partial benefits for mental health or chemical dependency services and meets the definition of other similar plans as described in the Coordination of Benefits section of the Medical Plan.

**Outpatient** — An ambulatory eligible participant receiving covered services who has not been admitted to a hospital or facility.

**Post-Service Claim** — Any claim for a benefit under a plan that is not a Pre-Service Claim.

**Pre-Service Claim** — Any claim for a benefit under a plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
**Pre-admission Certification** — Evaluating and certifying the necessity of a non-emergency admission to a facility provider. Pre-admission certification must be obtained from HMC/APS.

**Provider or Professional Provider** — A clinical social worker, marriage/family/child counselor, psychologist, or psychiatrist, who is licensed or certified by state and federal laws to provide mental health or chemical dependency services.

**Appeals Process for Behavioral Health Services**

**Policy**

All adverse determinations involving the provision of mental health and chemical dependency benefits can be appealed through the following appeal procedures maintained by HMC/APS. These appeal procedures must be exhausted before a participant may file suit under Section 502(a) of ERISA. An appeal may be submitted either in writing or via telephone call to HMC/APS by the participant or his or her health care provider. An appeal must be filed no later than 180 days following the individual's notification of the denial for the services in question.

**Level 1 Appeals**

A Level 1 appeal will be handled as expeditiously as possible but no later than:

- For post-service claims, within 30 days after receipt of the standard Level 1 appeal request;
- For pre-service claims, within 15 days after receipt of the standard Level 1 appeal request; and
- For urgent care claims, within 72 hours of the standard Level 1 appeal request.

Any denial of a Level 1 appeal will provide the following information:

- The reason for the denial;
- A reference to the Plan provision relied on;
- A description of any additional materials needed to perfect the claim;
- An indication of any internal guidelines or protocols that have been relied on in denying the claim and a statement that such internal guidelines are available on request;
- If the denial is based on medical necessity, a determination that a service or supply is experimental or investigational in nature, or other decisions requiring medical judgment, a statement that an explanation of the medical judgment involved will be provided on request;
- A statement that an individual is entitled to receive on request copies of all documents, records, and other information relevant to the appeal; and
- Notification of the individual’s right to request and initiate a second Level appeal.

**Level 2 Appeal**

A standard Level 2 appeal is offered if a standard Level 1 appeal has either upheld the adverse determination or resulted in only a partial reversal of the denial or adverse benefit determination.
The standard Level 2 appeal will be handled within the same time periods as Level 1 post-service or urgent claim appeals as outlined above. Any medical review on the Level 2 appeal will be done by an individual who was not involved in the previous review, and is not supervised by such a person. The reviewer will be of the same or similar clinical discipline that typically treats the condition in question or administers the procedures or provides treatment.

If the adverse determination is upheld on the second Level appeal, the same information will be provided as on the first Level appeal with the additional information that the individual may request the Board of Trustees of the Trust to independently review the denial of benefits.

**Urgent Care Claims**

These appeal procedures are modified in regard to urgent care claims in the following manner:

- An appeal may be requested verbally or in writing by either the participant or the individual’s health care provider without any prior written authorization;
- An individual will be notified within 24 hours if any additional information is necessary to complete the appeal and will have up to 48 hours to submit the additional information; and
- A decision will be made within no later than 72 hours following the receipt of an urgent care appeal.

**Review by the Board of Trustees**

An individual who has gone through the Level 1 and 2 appeals and has continued to have an adverse benefit determination may proceed under the Trust claim appeal procedures which are set forth in this Booklet. An appeal to the Board of Trustees shall be initiated by submitting a request to the participant’s Area Administrative Office.
Catastrophic Needs Medical Plan

This section explains the medical benefits provided to Active Regular Employees working under the National Master Freight Agreement who have more than 60, but less than 100, compensable hours in a month.

For Active Regular Employees who are under the Catastrophic Needs Medical Plan, the Indemnity Medical benefits described here are the only benefits available. Active Regular Employees in the Catastrophic Needs Medical Plan do have options to self-pay the monthly difference and receive the full benefits provided under the Active Plan.
Catastrophic Needs Medical Plan

Eligibility

As described in the Eligibility Section pages 4 to 10, you are eligible for the Catastrophic Needs Medical Plan if you are an Active Regular Employee working under the National Master Freight Agreement and have at least 60, but less than 100, compensable hours in a month and your employer makes the required contributions to the Trust. This eligibility rule does not apply to Casual Employees, employees covered by the National Car Haul Agreement, or other employees not working under the National Master Freight Agreement.

When Coverage Begins

The Trust uses a lag month system. Hours compensated in a month provide coverage in the second following month. For example, if an employee has more than 60, but fewer than 100, compensable hours in July, he will be under the Catastrophic Needs Medical Plan in September. If he has more than 100 compensable hours in August, he will return to the Active Regular Plan in October.

Benefits Provided

Benefits under the Catastrophic Needs Medical Plan are only provided through the Trust’s Indemnity Medical Program (including the mental health and chemical dependency benefits provided through HMC/APS). There are no HMO options available. If you have elected an HMO option (Kaiser, PacifiCare, Group Health, Lovelace, Presbyterian, Select Med), it will not be available in a month you are eligible under the Catastrophic Needs Medical Plan. If you subsequently have more than 100 compensable hours in a month, you will return to the HMO option you have selected the first day of the second month as outlined above.

The benefits provided under the Catastrophic Needs Medical Plan are those provided under the Indemnity Medical Program for Active Regular Employees with the following exceptions:

- **Annual Calendar Year Maximum**: $100,000.
- **Annual Deductible**: $500 per person (maximum three per family). This deductible is accounted for separately and any amounts accumulated under the Active Plan are not applied to the Catastrophic Needs Medical Plan’s deductible.
- **Coinsurance**: 75% of PPO allowed amount if PPO provider used; 60% of usual, customary, and reasonable (UCR) if non-PPO provider used.
- **Annual Out-of-Pocket Maximum**: There is no cap on your annual out-of-pocket maximum under the Catastrophic Needs Medical Plan. If you become disabled under the Catastrophic Needs Medical Plan, there is no extension of benefits for you or your dependents. The only way coverage can be continued is pursuant to COBRA procedures.
Under the Catastrophic Needs Medical Plan, there are no benefits for prescription drugs, dental, vision, time loss, life, or AD&D.

**BUY UP OPTIONS**

If you are placed under the Catastrophic Needs Medical Plan, the Trust will allow you to buy up and to receive the benefits under the Active Plan using the following options:

**Self-Pay for Active Regular Prescription Drug Coverage**

You may elect to self-pay for Active Regular prescription drug coverage. If you elect this option you will have the medical benefits provided under the Catastrophic Needs Medical Plan (which does not include prescription drug coverage) and the prescription drug coverage provided to Active Regular Employees. The amount of the buy up for prescription drug coverage is determined annually. You will be informed of the buy-up amount when you become eligible for the Catastrophic Needs Medical Plan. If you do not buy up for the first month, you cannot buy up for any subsequent month.

**Self-Pay for Active Regular Medical and Prescription Drug Coverage Only**

You may self-pay the difference between the $350 per month employer contribution made on your behalf and the actual cost for Active Regular Employee medical and prescription drug coverage. The amount of the buy up is determined annually. You will be informed of the buy-up amount when you become eligible for the Catastrophic Needs Medical Plan. If you do not elect to buy up for the first month, you cannot buy up for any subsequent month.

**Self-Pay for Active Regular Medical, Prescription Drug, Dental, and Vision Coverage**

You may also elect to self-pay the difference between the $350 per month employer contribution and the actual cost for Active Regular Employee medical, prescription drug, dental and vision coverage. The amount of the buy up is determined annually. You will be informed of the buy-up amount when you become eligible for the Catastrophic Needs Medical Plan. If you do not buy up for the first month, you cannot buy up for any subsequent month.

**Self-Pay for Coverage under COBRA**

Federal law also requires you be offered an opportunity to self-pay for coverage under COBRA if you lose eligibility under the Active Plan. You may purchase either Active Regular Employee medical and prescription drug only or Active Regular Employee medical, prescription drug, dental, and vision. This is the same coverage offered under options described above. You will receive no credit for the $350 per month contribution made on your behalf and will be required to self-pay the full cost of COBRA coverage. For terms under which COBRA coverage are provided, please contact your Area Administrative Office.

You should be aware that if your Trust coverage subsequently ends in its entirety, you will also be given an opportunity at that time to elect COBRA continuation coverage.
Indemnity Dental Benefits – Actives Only

This section explains the dental benefits available to Active Plan participants and their covered dependents, including those who have selected an HMO medical plan. However, these benefits do not apply if you select an alternate dental plan.

The dental benefits described in this section are not available to participants or dependents in the Casual Plan and the Catastrophic Needs Medical Plan.
Indemnity Dental Benefits for You and Your Covered Dependents — Actives Only

Dental benefits are available to Active Plan participants only. They are not available to the Casual Plan and Catastrophic Needs Medical Plan participants and dependents.

You may choose a dental plan either at the time you become initially eligible or during the Trust’s annual open enrollment period. If you do not make an election, you will be placed automatically in the Trust’s Dental Plan. If you previously chose an alternate dental plan, you will continue to participate in that plan until you revoke your election. You and your dependents must participate in the same dental plan.

Alternate Dental Plan Options

Alternate dental plans are available for employees and dependents living in the areas serviced by the providers listed below:

- Safeguard Dental – California and Arizona (Safeguard is not accepting new patients in Arizona).

These alternate dental plans are described in separate booklets provided by the alternate dental provider. Contact your Area Administrative Office if you have questions.

Indemnity Dental Plan Benefits

The dental benefits described in this Booklet are your dental benefits if you did not elect to enroll in one of the alternate dental plans above. The dental benefits in this section are provided and funded by the Trust.

The Trust reimburses you for covered dental services provided to you or your eligible dependents up to the usual, customary, and reasonable allowable amount subject to the following provisions and exclusions.

Calendar Year Deductible

You and each of your covered dependents must pay a calendar year deductible of $50 in eligible expenses before the Trust Dental Plan pays benefits. The $50 deductible needs to be met only once during a calendar year even if the individual has several dental visits or treatments. To satisfy your $50 deductible, submit all dental charges to your Area Administrative Office. They will apply all eligible charges until the $50 has been reached.
Usual, Customary, and Reasonable (UCR)

Usual, customary, and reasonable means the maximum amount the Trust will consider for reimbursement. The amount is determined by comparing the actual charge for the services or supplies with the prevailing charges usually made by the provider when there is not health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust or its medical consultants will determine the prevailing charge.

Annual Benefit Maximum

The maximum payment is $2,000 per covered person each calendar year.

Payment Levels

The Trust will reimburse the fee charged by the dentist for eligible services up to the usual, customary, and reasonable (UCR) allowable amount, after deductible, at the levels shown below. If more than one dentist provided services in connection with a dental service performed on an individual, the benefit will not exceed the amount that would be payable if such service had been provided by only one dentist.

<table>
<thead>
<tr>
<th>PAYMENT LEVELS FOR BENEFITS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>85% of usual, customary,</td>
</tr>
<tr>
<td></td>
<td>and reasonable (UCR)</td>
</tr>
<tr>
<td>Basic Care</td>
<td>80% of usual, customary,</td>
</tr>
<tr>
<td></td>
<td>and reasonable (UCR)</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>50% of usual, customary,</td>
</tr>
<tr>
<td></td>
<td>and reasonable (UCR)</td>
</tr>
</tbody>
</table>

Alternative Dental Treatments

The Trust considers the least expensive services and supplies that are appropriate and meet acceptable dental standards as covered charges. If a condition is being treated for which two or more services are suitable under customary dental practices, the benefits will be based on the least expensive of the services.

Predetermination of Benefits

If your dental work is likely to cost over $200, you may ask your dentist to send a treatment plan to your Area Administrative Office before beginning your dental work. This “predetermination of benefits” will allow you to know how much the Trust will pay toward your dental work, and help you budget for your out-of-pocket dental expenses. The Area Administrative Office will let you and your dentist know ahead of time the estimated amount that will be covered by the Trust.
Covered Dental Services

For a dental charge to be covered, it must be performed by a legally qualified dentist, licensed dental hygienist working under the direction of a legally qualified dentist, or a licensed denturist providing services within the scope of his or her license.

The following charges, up to the usual, customary, and reasonable (UCR) allowable amount, are covered dental services:

- Oral examination (including emergency exams), two per calendar year.
- Prophylaxis and periodontal maintenance, two per calendar year.
- Topical application of fluoride for children through age 18, one application per child per calendar year.
- Sealants for children through age 18, once in any three-year period per tooth. Also limited to first and second molars with no previous cavities.
- X-rays:
  - Full mouth set of x-rays, including panoramic, one series per calendar year.
  - Bite wing x-rays, two sets per calendar year.
- Space maintainers for children under age 13.
- Extractions.
- Restorative type fillings.
- General anesthetic when administered with oral surgery (certain guidelines apply).
- Treatment of periodontal and other diseases of the gums and tissues supporting the teeth.
- Endodontic treatment, including root canal, if tooth is opened while the patient is covered by the Trust.
- Re-cementing of crowns, inlays, and bridgework.
- Relining of dentures.
- Inlays, onlays, gold fillings, or crowns when teeth cannot be restored with a filling material, or where the tooth serves as an abutment for a bridge.
- Initial installation of full or partial dentures, dental implants, and fixed bridgework, including inlays, and crowns, to replace one or more natural teeth.
- Replacement of existing bridgework or implants by new bridgework or implants, or the addition of teeth to existing dentures or bridgework, only if the existing denture, bridgework, or implant cannot be made serviceable and was installed more than five years ago.
**INDEMNITY DENTAL BENEFIT EXCLUSIONS**

Indemnity Dental benefits are not payable for any of the following items:

1. Services or supplies subject to the General Exclusion applicable to all benefits. See pages 87 to 88.
2. Jaw treatment for temporomandibular joint dysfunction (TMJ), and myofascial pain dysfunction (MPD). Treatment may be provided under the Trust’s medical benefits.
3. Anything not furnished by a dentist, except:
   - X-rays ordered by a dentist;
   - Services provided by a licensed hygienist under a dentist’s supervision; and
   - Services and supplies provided by a licensed denturist.
4. Expenses for orthodontic services and supplies for adults (a program to straighten teeth) or furnished for cosmetic purposes unless made necessary by accidental injury while the patient is covered by the Trust. See page 73 for orthodontic benefits for covered dependent children.
5. Replacement of lost or stolen appliances, appliances, or restorations for the purpose of splinting to increase vertical dimension or restore occlusion.
6. An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge, or gold restoration for which the tooth was prepared before the patient was covered; and root canal therapy if the pulp chamber was opened before the patient was covered.
7. A crown, gold restoration, denture, dental implant, fixed bridge, or addition of teeth to a fixed bridge, if the work involves a replacement or modification of a crown, gold restoration, denture, dental implant, or bridge installed less than five years before and for which a benefit was payable under the Dental Expense Benefit. This exclusion does not apply if the replacement and modification of a crown of less than five years is due to dentally necessary treatment of the underlying tooth or structure and the existing crown cannot be saved.
8. The replacement of a partial or full removable denture or fixed bridgework if denture or bridgework can be satisfactorily repaired.
9. Procedures that were started prior to the individual becoming covered by the Trust Dental Plan.
10. Charges for broken appointments with a dental provider.
11. Charges for treatments, materials, or supplies that are experimental or investigational in nature.

Dental charges not payable under this Trust, or in excess of the usual, customary, and reasonable (UCR) allowable amount, are not eligible expenses under the Trust’s medical benefits. These charges may not be used to satisfy the Medical benefit plan deductible except for charges incurred for certain dental services (see Dental Services on page 33), and then only to the extent that they are eligible expenses under the Trust’s medical benefits.

**Administration of Dental Benefits/Extended Benefits**

Certain dental procedures (such as crowns, inlays, dentures, etc.) can involve a delay between when an impression is taken and the prosthetic is delivered or seated. To receive benefits in such situations, you must be eligible on both the date the impression is taken and on the date when the prosthetic is delivered or seated (subject to the one-month extension available under the Extended Benefit provision discussed below). Benefits are determined on the date that the prosthetic is
seated or delivered and are applied toward the Annual Benefit Maximum based on that date as well.

If the Dental Expense Benefit terminates and you or your covered dependent are under the care of a dentist, the benefits will be extended one month for any eligible dental service that was already started, provided the work is done by the same dentist and benefits would have been paid had the coverage remained in effect. In no event will diagnosis, prophylaxis, or the taking of x-rays constitute a service started. This extension does not apply to orthodontic benefits. When this Extended Benefits provision applies, it will operate only to the extent that coverage is not otherwise provided for the person through the Trust.

ORTHODONTIC BENEFIT FOR YOUR COVERED DEPENDENT CHILDREN

This benefit applies to active orthodontic treatment to straighten teeth for a child who is covered under the Trust Dental Plan.

<table>
<thead>
<tr>
<th>SCHEDULE OF BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Percentage</td>
</tr>
<tr>
<td>Lifetime Maximum, Per Child</td>
</tr>
</tbody>
</table>

A child must be covered for the month the service is provided for benefits to be payable. In no event will the benefits be greater than the dentist’s charges for the treatment.

For purposes of determining benefits, the treatment period begins when an active appliance is installed and ends when the appliance is removed.

Covered Orthodontic Services

- X-rays ordered by a dentist.
- Services provided by a licensed dental hygienist under a dentist’s supervision.
- Services and supplies provided by a licensed or certified denturist.

How Benefits Are Paid

Orthodontic benefits are paid at 50% when orthodontic bands are installed and then 50% of eligible charges on a monthly basis.

Orthodontic Benefit Exclusions

The orthodontic benefit under this Plan does not cover:

- Services or supplies subject to the General Exclusions applicable to all plans. See pages 87 to 88.
- Services or supplies provided by a non-dentist.
- Services and supplies not necessary or customarily provided for dental care.
- Charges incurred after an active appliance is removed.
This section explains the vision benefits available to all Active and Casual Plan participants and their covered dependents, including those who have selected an HMO medical plan. These benefits are not available if you are under the Catastrophic Needs Medical Plan.

The Trust’s vision benefits are provided and administered by VSP.
Vision Care Benefits for You and Your Covered Dependents

Your vision care plan, provided and administered by VSP, features a network of over 35,250 doctor access points nationwide, who provide professional vision care for participants and their dependents covered under the Plan. This assures professional eye care and eyewear at a uniform cost.

**HOW TO USE THE PLAN WHEN CARE IS PROVIDED BY A VSP NETWORK DOCTOR**

When using a VSP network doctor, you and your eligible dependents have the following benefits:

**Vision Examination**

A complete analysis of the eyes and related structures to determine the presence of vision problems, abnormalities, or to determine the need for corrective lenses. Available every 12 months from the last date of service and covered in full by the Trust after a $15 co-pay.

**Lenses**

The VSP network doctor will order the proper lenses. The program provides quality lenses fabricated to exacting standards. The VSP doctor also verifies the accuracy of the finished lenses. Available every 12 months from the last date of service and covered in full by the Trust after a $25 co-pay (combined with frames). Any cosmetic lens option will be an out-of-pocket expense to the patient. There is an average 30% savings on lens options like progressives, scratch-resistant, and anti-reflective coatings.

**Frames**

The Plan offers a wide selection of frames. However, if you select a frame that costs more than the Plan allowance (or a large frame that requires oversize lenses), you will be responsible for the additional charge. Frames are available every 24 months from the last date of service. A frame of your choice is covered up to $130, plus 20% of any out-of-pocket cost. The $25 materials co-pay will apply (combined with lenses).

**Contact Lenses**

You may choose contacts instead of prescription glasses. Your $90 allowance applies toward the cost of a routine vision exam, contacts, and contact lens exam (fitting and evaluation). The contact lens exam is in addition to your routine vision exam to ensure proper fit of your contacts available every 12 months from the last date of service.

In addition to the benefits above, VSP also provides the following extra discounts and savings when you use a VSP network doctor:
Prescription Glasses

- 20% discount on additional prescription glasses and sunglasses.
- 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.

Contacts

- 15% discount on the cost of your contact lens exam (fitting and evaluation). The contact lens exam discount applies to the doctor’s professional fee that includes fitting and evaluation to ensure proper fit of contacts. Discount does not apply to contact lens purchase.
- Exclusive pricing for an annual supply of contact lenses is available for many popular brands.

Laser Vision Correction Discount

VSP has arranged for members to receive PRK, LASIK, and Custom LASIK at a discounted fee from VSP network doctors. You will receive an average 15% discount on the contracted laser center’s usual and customary price or 5% off the promotion price from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor within 12 months of your last eye exam.

Benefit Co-payments

When you select a doctor from the VSP network, your exam, professional services, lenses, and frames will be subject to the following co-pays:

<table>
<thead>
<tr>
<th>CO-PAYS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$15 co-pay</td>
</tr>
<tr>
<td>Lenses and/or frames*</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Contacts</td>
<td>No co-pay applies</td>
</tr>
</tbody>
</table>

* If you select a frame that costs more than the Plan allowance, you will be responsible for the additional cost.

Co-pays should be paid to the VSP network doctor at the time of the service. Payment for additional care, service, and/or eyewear not covered by this Plan may be arranged between you and your doctor.

Accessing Care and Receiving Benefits from VSP Network Doctors

1. To find a VSP network doctor, call VSP at 800-877-7195 or visit www.vsp.com.
2. Make an appointment with your VSP network doctor. Identify yourself as a VSP member and give the Trust participant’s social security number. Your doctor and VSP will handle the rest.
3. You pay the doctor a $15 co-pay for the exam, and a $25 co-pay if you purchase lenses and/or frames.
4. You do not need to file any claim forms.
**HOW TO USE THE PLAN FOR NON-VSP PROVIDER CARE**

If you choose to use a non-VSP optometrist, ophthalmologist, or dispensing optician, benefits are provided based on the non-VPS provider reimbursement schedule and co-pays still apply.

If you choose to use a non-VSP provider, you pay the provider in full at the time of service. You will be reimbursed by VSP up to the fee schedule below after a $15 co-pay for exam services and a $25 co-pay for lenses and/or frames. There is no assurance that this will cover all the expenses.

### NON-VSP PROVIDER

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>PLAN PAYS UP TO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Exam, available every 12 months</strong></td>
<td>$27.50</td>
</tr>
<tr>
<td><strong>Lenses and Frames, Per Pair</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses, available every 12 months</td>
<td>$31.00</td>
</tr>
<tr>
<td>Bifocal Lenses (lined), available every 12 months</td>
<td>$48.00</td>
</tr>
<tr>
<td>Trifocal Lenses (lined), available every 12 months</td>
<td>$58.00</td>
</tr>
<tr>
<td>Frames, available every 24 months</td>
<td>$50.00</td>
</tr>
<tr>
<td><strong>Eye Exam, Fitting &amp; Evaluation and Contacts</strong></td>
<td></td>
</tr>
<tr>
<td>Available every 12 months</td>
<td>$90.00</td>
</tr>
</tbody>
</table>

Availability of service under this reimbursement schedule is subject to the same time limits as those described for VSP network doctors, and are in lieu of obtaining these services from a VSP network doctor.

**Extra Cost Items**

This Plan is designed to cover your visual rather than cosmetic needs. You pay for:

- Blended lenses.
- Contact lenses (except as noted elsewhere herein).
- Oversize lenses (61mm or larger).
- Progressive multi-focal lenses.
- Coated lenses.
- Laminated lenses.
- A frame that costs more than the Plan allowance.

**VISION BENEFIT EXCLUSIONS**

Vision care benefits are not payable for any of the following items:

1. Services or eyewear subject to the General Exclusions applicable to all benefits. See pages 87 to 88.
2. Orthoptics or vision training and any associated supplemental testing.
3. Plano lenses.
4. Two pair of glasses instead of bifocals.
5. Lenses and frames provided under this Plan that are lost or broken will not be replaced except at normal intervals when services are otherwise available. Medical or surgical treatment of the eyes (may be covered under the medical plan).
6. Any eye exam or corrective eye wear required by an employer as a condition of employment.
7. Subnormal vision aids.

VSP may, at its discretion, waive any of the limitations if, in the opinion of our optometric consultants, it is necessary for the visual welfare of the covered person.

**Filing a Vision Care Claim for Reimbursement**

For timely reimbursement, go online to [www.vsp.com](http://www.vsp.com), select the *Out-of-Network Reimbursement Form*, and follow the instructions. If you do not have internet access, send your itemized statement of charges to VSP with the participant’s name, social security number, the patient’s name, date of birth, and relationship to the participant, and state that your coverage is under the Western Teamsters Welfare Trust. Your claim must be submitted within 12 months of completion of services. Keep a copy of the claim and submit your originals to:

VSP  
P.O.Box 997105  
Sacramento, California 95899-7105

If you have any questions, call VSP at 800-877-7195.

**Processing Vision Care Claims**

VSP will pay or deny claims for Plan benefits provided to you and your eligible dependents, after any co-pay, within 30 days after VSP receives a completed claim, unless special circumstances require additional time. In this case, VSP may obtain an extension of 15 days by providing notice of the reasons for the extension.

**Appeal of Denied Claims**

Under the Plan, if a claim is denied in whole or in part, you or your authorized representative may request a full review of the denial. You may designate any person, including your provider, as your authorized representative.

**Initial Appeal**

The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Trust participant for whom the claim was denied, including the VSP enrollee’s name, the VSP enrollee’s member identification number, the Trust participant’s name and date of birth, the provider’s name, and the claim number. You may review during normal working hours any documents held by VSP pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in VSP’s review. VSP’s response to the initial appeal, including specific reasons for the decision, will be provided and communicated to you as follows:
• Prior authorization for visually necessary or appropriate services: within 30 calendar days after receipt of your request for an appeal.
• Denied claims for services rendered: within 30 calendar days after receipt of your or your authorized representative’s request for an appeal.

Second Level Appeal

If you or your authorized representative disagree with the response to the initial appeal of the claim, you or your authorized representative have the right to a second level appeal. Within 60 days after receipt of VSP’s response to the initial appeal, you or your authorized representative may submit a second appeal to VSP along with any pertinent documentation. VSP will communicate its final determination to you or your authorized representative in compliance with applicable state and federal laws and regulations and will include the specific reasons for the determination.

Other Remedies

If you remain dissatisfied after completing the VSP appeals process, you may request the Trust’s Board of Appeals to review your appeal. Details about how to access the Trust Claims Appeal Procedure are set forth on page 96 to 103. Additionally, under the provisions of ERISA, you or your authorized representative have the right to bring a civil action after you have exhausted the Claims Appeal Procedure.
This section explains the life insurance and accidental death and dismemberment benefits available to Active and Casual Plan participants and their covered dependents, including those who have selected an HMO medical plan.

Life insurance benefits are available to Active and Casual Plan participants and their covered dependents.

AD&D benefits are available to Active and Casual Plan participants with no coverage for dependents.

The Trust’s life and AD&D insurance benefits are provided and administered by Prudential Insurance Company of America.

Life and AD&D benefits are not available to participants in the Catastrophic Needs Medical Plan.
Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits

EMPLOYEE TERM LIFE INSURANCE

<table>
<thead>
<tr>
<th>SCHEDULED BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Employees $8,000</td>
</tr>
<tr>
<td>All Other Employees $2,000</td>
</tr>
</tbody>
</table>

Death Benefit

If you die from any cause while insured for Term Life Insurance under this Plan, your beneficiary will receive the scheduled benefit in effect on the date of your death. If your beneficiary does not survive you, or if you have not designated a beneficiary, Prudential will pay:

- First, your spouse, if living, otherwise
- your surviving natural or adopted children in equal shares, then
- your surviving parents in equal shares, or the survivor of them, then
- your surviving brother(s) and sister(s) in equal shares, then
- your executors or administrators.

Designation of Beneficiary

You may designate a beneficiary by making the request in writing to your Area Administrative Office. You may change your beneficiary whenever you wish by submitting a new written request.

Insurance During Total Disability

If you become totally disabled before you reach age 60, the Trust will continue your Term Life Insurance until you reach age 65, at no cost to you, as long as you remain totally disabled. You must submit written proof of your total disability to Prudential no later than one year after the premium payments for your Term Life Insurance have ended. You will be required to submit proof of your disability each subsequent year. The provision will cease under certain conditions. However, in no event will it continue past age 65.

If you become totally disabled while age 60 or over, your Term Life Insurance will become payable if you die within 12 months from the date your insurance terminates (when premium payments cease), provided you were continuously disabled to the date of death and the group policy has not terminated.

Changing to an Individual Policy

During the 31 days following termination of your coverage under the Trust, you may change your Term Life Insurance, without having to furnish evidence of good health, to one of a number of...
individual life policies, excluding Term Life Insurance. The policy will be effective at the end of the 31-day period, and the premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. If you die during this 31-day period, your Term Life Insurance will be paid whether or not you have applied for an individual policy.

Should you become eligible again, you may not avail yourself of this provision if an individual policy is in effect as a result of a previous conversion.

These provisions for change to an individual policy will not be applicable if your insurance is continued as a result of an approved total disability, except in the event you recover from such total disability and apply for the individual policy within 31 days of such recovery.

**TERM LIFE INSURANCE FOR COVERED DEPENDENTS — SPOUSE AND CHILD(REN)**

The following amount will be paid to you (the employee), if one of your covered dependents dies. Term life coverage for covered dependents takes effect after he or she is 14 days old.

<table>
<thead>
<tr>
<th>SCHEDULED BENEFIT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse and each child</td>
<td>$ 500</td>
</tr>
</tbody>
</table>

**Changing to an Individual Policy**

If you should die or terminate your coverage under the Trust, the Term Life Insurance for your dependents will be continued for 31 days. During this period, arrangements may be made to change each dependent’s Term Life Insurance, without having to furnish evidence of good health, to one of a number of Prudential individual life policies. The policy will be effective at the end of the 31-day period, and the premiums will be the same as would ordinarily be paid if an individual policy were applied for at that time.

This privilege is also available for a covered dependent who ceases to be eligible for the Term Life Insurance.

**EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

The following amount will be paid for any of the losses listed below that are caused solely by external, violent, and accidental means on or off the job while you are insured. It is payable regardless of other insurance.
## SCHEDULE BENEFIT

<table>
<thead>
<tr>
<th>California Employees</th>
<th>$8,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-California Employees</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### LOSS

<table>
<thead>
<tr>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full amount of Scheduled Benefit (paid to your Term Life beneficiary)</td>
</tr>
<tr>
<td>Full amount of Scheduled Benefit (paid to you)</td>
</tr>
<tr>
<td>One-half the amount of Scheduled Benefit (paid to you)</td>
</tr>
</tbody>
</table>

Loss of sight means total and irrecoverable loss of sight. Loss of a hand or foot means loss by severance at or above the wrist or ankle.

### AD&D Limitations

The total payment for all losses due to any one accident will not be more than the full amount of the scheduled benefit. The loss must take place within 90 days of the accident.

### AD&D Benefit Exclusions

Accidental death and dismemberment insurance does not cover a loss which results from, or is caused directly or indirectly by:

1. Suicide, whether sane or insane.
2. Body or mental infirmity or disease, or medical or surgical treatment thereof.
3. Ptomaine or bacterial infection, except only septic infection of and through a visible wound accidentally sustained.
4. Any state of war, any act of war, an insurrection, or participation in a riot.
5. Travel in, or descent from, any aircraft aboard which you have any duties or give or receive any training.
Time Loss Benefits – Actives Only

This section explains the time loss benefits available only to Active Plan participants living outside California. The time loss benefits described in this section are not available to participants in the Casual Plan or the Catastrophic Needs Medical Plan or dependents.

Weekly time loss benefits are funded by the Trust.
Weekly Time Loss Benefits

WEEKLY TIME LOSS BENEFITS FOR ACTIVE PLAN PARTICIPANTS OUTSIDE CALIFORNIA

Only Active Plan participants who live outside California are eligible to receive Time Loss benefits. These benefits are not available to covered dependents or participants in the Casual Plan or Catastrophic Needs Medical Plan.

You will receive weekly payments if you are unable to work because of a covered, non-occupational accident or sickness. You must be under the regular care of a doctor and the disability must begin while you are eligible under the Trust for this benefit.

<table>
<thead>
<tr>
<th>SCHEDULED BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Benefit</td>
</tr>
<tr>
<td>(subject to FICA withholding)</td>
</tr>
</tbody>
</table>

<p>| PERIOD OF DISABILITY PRIOR TO BENEFIT PAYMENTS |</p>
<table>
<thead>
<tr>
<th>If Disability Results From:</th>
<th>Benefits Begin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an Accident</td>
<td>On the first day of disability.</td>
</tr>
<tr>
<td>a Sickness</td>
<td>On the eighth consecutive day of disability*.</td>
</tr>
<tr>
<td>an Inpatient Hospital Confinement</td>
<td>On the first day of confinement if during the seven-day waiting period.</td>
</tr>
</tbody>
</table>

*The seven-day waiting period begins on the day following your last day worked and the first day you are certified as disabled by a physician.

Maximum Benefit Payment Period

Payments will continue as long as you are disabled, to a maximum of 26 weeks for any one period of disability (including disability due to pregnancy).

Periods of disability due to the same cause will be considered the same period of disability unless they are separated by return to active, full-time work for at least two weeks. Periods of disability due to different causes will be considered different periods of disability if they are separated by return to active full-time work for at least two weeks.

TIME LOSS BENEFIT EXCLUSIONS

The weekly Time Loss benefits do not cover:

1. Time loss situations which are referred to in the General Exclusions applicable to all benefits. See pages 87 to 88.
2. Any period you are receiving old age insurance benefits under social security or age/disability retirement benefits under any Teamster Pension Plan.
3. Disabilities due to injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any workers’ compensation law, occupational disease law, or similar legislation.
4. Disabilities due to injury or illness which are or appear to be the responsibility of one or more third parties.
General Exclusions – Active, Casual and Catastrophic Needs Medical Plans

This section applies to all benefits previously described in this Booklet.
General Exclusions Applicable to All Benefits

All benefits described in this Booklet are subject to the following general exclusions. Benefits are not payable for:

1. Services or supplies obtained or Time Loss incurred when the individual is not eligible under the Trust.
2. Services or supplies determined not to be medically or dentally necessary. Medically or dentally necessary means that services or supplies (a) must be ordered through a physician or other qualified provider, (b) must be commonly and customarily recognized as appropriate in the treatment of the patient’s diagnosed injury or sickness as specified by authoritative medical or scientific literature, and (c) must be the least costly of the alternative services or supplies which can be safely provided. Medical necessity does not include maintenance or supportive type treatment or services. Such services or supplies must not be educational or experimental in nature or provided primarily for the purpose of medical or other research. The fact that a service or supply was furnished, prescribed, or approved by a physician or other qualified provider does not in itself mean it was medically necessary. A medical service, supply, or setting may be medically necessary in part only. The Trust may utilize the services of its medical review organizations or their internal guidelines or protocols to determine medical necessity for certain services.
3. Any expense or charge for which you or a covered dependent are not financially responsible.
4. The portion of a charge for a service or supply in excess of the usual, customary, and reasonable charge. Usual, customary, and reasonable means the maximum amount the Trust will consider for reimbursement. The amount is determined by comparing the actual charge for the services or supplies with the prevailing charges usually made by the provider when there is not health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust or its medical consultants will determine the prevailing charge.
5. Any expenses or charges for services or supplies which are considered experimental or investigational treatment, as determined by the Trust or its medical consultants. Experimental or investigational treatment means any services, including a treatment, procedure, facility, equipment, drug, drug usage, medical device, or supplies that, as determined by the Trust or its medical consultants, meets one or more of the following criteria:
   - A drug or device that cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date it is furnished.
   - A facility or provider that has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases.
   - Reliable evidence shows the service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
   - Reliable evidence shows the service is not safe and effective for a particular medical condition, as compared to other generally available services, and that it poses a significant risk to the patient’s health or safety.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature, scientific results of the provider of care’s written protocols, or scientific data from another provider studying the same service.

6. Services or supplies obtained or time loss incurred as a result of an injury or illness, which is covered under a workers’ compensation program or where a claim for such coverage has been made. However, where a contested claim for workers’ compensation is pending, benefits otherwise subject to this exclusion may be paid if you or your dependent observe the Trust’s requirements for advancement of benefits. See Advancement of Benefits provision on page 93.

7. Services or supplies obtained or time loss incurred as a result of an injury or illness which is, or appears to be, the responsibility of one or more third parties and for which payment is or may be made by a third party, or by one or more insurance companies whose insurance policies have become applicable. The term insurance includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability, homeowner’s liability, umbrella liability, and medical payments or PIP coverages, regardless of whether such insurance is maintained by the injured person, by a third party, or by any other person or entity. However, where a third-party claim is pending, benefits otherwise subject to this exclusion may be paid if you or your dependent observe the Trust’s requirements for advancement of benefits. See Advancement of Benefits provision on page 93.

8. Services or supplies or time loss payments furnished by or for a federal, state, or other governmental agency, unless the Trust is required to pay by applicable law, or to the extent benefits are provided under any governmental program or law under which the individual is or could be covered. This exception does not apply to state plans under Medicaid or to any law or plan which states that its benefits are excess to those of any private insurance program or other non-governmental program.

9. Services, supplies, or time loss payments required for an injury or illness or any loss incurred as a result of military service or as a result of an act of war.

10. Services or supplies for treating an injury or illness while legally confined in a penal institution, mental hospital, or other government facility, or during participation in criminal activities.

11. Charges for any services rendered by you, your spouse, or any member of your immediate family.

12. Services or supplies or time loss or death benefits for which a properly completed claim form is not submitted within 12 months of the date the services or supplies are provided or the disability or death has taken place.

13. Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipient, and on cadavers.

Services or supplies used in these General Exclusions include prescription drugs.

These general exclusions apply to all benefits described in this Booklet. Additionally, you should check the specific exclusions for each type of benefit offered by the Trust. Specific exclusions are contained in the following pages of your Booklet:
<table>
<thead>
<tr>
<th>Specific Benefit Exclusions</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Medical Benefit Exclusions</td>
<td>39</td>
</tr>
<tr>
<td>Prescription Drug Benefit Exclusions</td>
<td>52</td>
</tr>
<tr>
<td>Mental Health and Chemical Dependency Benefit Exclusions</td>
<td>59</td>
</tr>
<tr>
<td>Indemnity Dental Benefit Exclusions</td>
<td>72</td>
</tr>
<tr>
<td>Vision Benefit Exclusions</td>
<td>77</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Benefit Exclusions</td>
<td>83</td>
</tr>
<tr>
<td>Time Loss Benefit Exclusions</td>
<td>85</td>
</tr>
</tbody>
</table>
Plan Administration – Active, Casual and Catastrophic Needs Medical Plans

This section explains how the Active, Casual and Catastrophic Needs Medical Plans are administered. It applies to all Plan participants and their covered dependents.
Coordination of Coverage With Other Plans

(Does not apply to the Prescription Drug Benefits)

This Trust coordinates its benefits with other similar plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable expenses. This provision applies to the Trust’s medical, dental, vision and mental health and chemical dependency benefits.

If Both Spouses are Covered Under the Trust’s Plans

When a person is covered under this Trust in more than one capacity (either as an employee and as a dependent of another employee, or as a dependent child of more than one employee), coverage of the person in each capacity will be considered separately for purposes of this provision, and this provision will apply separately to the coverage of the person in each capacity as though coverage in one capacity was the primary plan and coverage of the person in the other capacity was the secondary plan.

Where there is dual coverage and a dollar limitation on benefits, an individual will receive benefits for qualified services up to the dollar limitation under both the primary and secondary coverage. Where there is a limit based on a number of visits, however, an individual will receive only benefits for qualified services up to the Plan limit.

Definitions

Allowable Expense - Any necessary, reasonable, and customary expense covered, at least in part, by one of the plans of the same type (medical, dental, or vision care).

Plans - The following types of medical, dental, vision, and mental health and chemical dependency benefits: (a) a governmental program (except Medicaid but including Medicare)* other than for a motor vehicle insurance contract, or (b) group insurance or other coverage for a group of individuals, but not including franchise insurance or student coverage obtained through an educational institution.

This Trust - Medical, dental, vision, mental health and chemical dependency benefits described in this booklet, excluding the Prescription Drug Program.

Effect on Benefits

Benefits otherwise payable under this Trust for allowable expenses during a claim determination period may be reduced if:

* See section “Modified Health Care Coverage for Medicare Eligible Participants” on page 93.
1. Benefits are payable under any other plan for the same allowable expenses; and
2. The rules listed in “Order of Benefit Determination” on page 92 provide that benefits payable under the other plan are to be determined before the benefits payable under this Trust.

The reduction will be the amount needed to provide that the sum of payment under this Trust plus benefits payable under the other plan(s) does not exceed 100% of allowable expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Trust.

For this purpose, benefits payable under other plans will include the benefits that would have been paid had claims been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

If another plan which is primary under this Trust’s coordination of benefit rules limits the available benefits based on the existence of other group health coverage, this Trust will pay its benefits based on what the other plan would have paid if no other group health coverage existed. A determination whether another plan limits coverage based on the existence of other group health coverage shall be determined in the sole discretion of the Board of Trustees of this Trust.

**Order of Benefit Determination**

Except as described under “Modified Health Care Coverage for Medicare Eligible Persons” on page 93, the benefits payable by a plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a plan that does have such a provision. In all other instances, the order of determination will be:

1. Employee/Dependent - The benefits of a plan that covers the person for whom benefits are claimed as an employee, member, or subscriber (but not a retiree) are determined before the benefits of a plan that covers the person as a dependent.
2. Dependent Child – Parents Not Divorced. When this Trust and another plan cover the same child as a dependent, the benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
3. Dependent Child – Divorced Parents. If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   - First, the plan of the parent with custody of the child, then
   - The plan of the spouse of the parent with custody of the child, and finally
   - The plan of the parent not having custody of the child.

However, if the specific terms of a legally enforceable court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any
claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefit of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee’s dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee’s dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

5. Continuation Coverage. If a person is provided coverage under a federal or state continuation law and is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as the person’s dependent) is primary and the continuation coverage is secondary.

6. Longer/Shorter Length of Coverage. If none of the previous rules determine the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.

Benefit Credit Provision

When this Trust is secondary and its payment is reduced because of the primary plan’s benefits, a record is kept of the reduction. This amount will be used to increase this Trust’s payments on the patient’s later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Trust and the others. This provision does not apply to your Dental Plan.

Modified Health Care Coverage for Medicare Eligible Participants

If the individual is:

- An active employee age 65 or over and has elected to retain this Trust as his/her primary coverage, or
- A dependent spouse age 65 or over of an active employee and has elected to retain the Trust as his/her primary coverage, then coordination with other plan’s provisions listed previously will not apply to that person’s Medicare coverage. Instead, Medicare will adjust its benefits, as required by law, to take into account benefits payable under this Trust. This provision does not apply to your dental, vision, prescription drug, and mental health and chemical dependency benefits.

Workers’ Compensation and Third-Party Liability Situations — Advancement of Benefits

If you or a dependent require services or supplies or time loss payments as a result of a sickness or injury that is covered by workers’ compensation, or where a claim for workers’ compensation coverage has been filed, such charges are not covered by this Trust. See “General Exclusions,” number 6 on page 88.

Similarly, if you or a dependent require services or supplies or time loss payments as a result of a sickness or injury which is, or appears to be, the responsibility of one or more third parties and for which payment is or may be made by a third party, or by one or more insurance companies whose
insurance policies have become applicable, such charges are not covered by this Trust. The term “insurance” includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability, homeowner’s liability, umbrella liability, and medical payments or PIP coverages, regardless of whether such insurance is maintained by the injured person, by a third party, or by any other person or entity. See “General Exclusions,” number 7 on page 88.

However, if you or a dependent submit a claim for Trust benefits and there is a contested workers’ compensation claim pending, or a third-party claim pending, benefits will be advanced for you or your dependent if you sign the Trust’s Agreement to Reimburse form including the following obligations:

- The amount of all Trust benefits advanced will be included in the pending claim;
- The injured person, or his/her attorney, will provide the Trust, upon request, with updates on the status of the claim and the achievement of any recovery; and
- When any recovery is obtained, whether by direct payment or settlement (including a “disputed claim” settlement), or by award, judgment, or in any other way, the injured person or his/her attorney will promptly reimburse the Trust the full amount of all benefits advanced to the date of recovery, less only a deduction representing the Trust’s proportionate share of the injured person’s reasonable attorney fees and costs (if any).

It will not be necessary for the Trust to file a “lien” in order to obtain reimbursement. The Agreement to Reimburse will apply whether or not liability is admitted by the responsible party or insurance company and whether or not reimbursement of the Trust’s benefit payments is mentioned in the payment, settlement documents, or in the award or judgment. The Trust reserves the right to first and full reimbursement out of any recovery obtained by the injured person, regardless of how such recovery has been calculated or is described and regardless of whether the individual has been made whole. The Trust may waive or modify this right, through Trust policy, where the circumstances warrant.

In the event the Trust discovers that it has unknowingly advanced benefits in a workers’ compensation or third-party liability situation, but the injured person declines to sign an Agreement to Reimburse, or the Trust has a basis for believing an individual will not observe the terms of an Agreement to Reimburse the Trust will suspend or deny payment of all benefits and assess an overpayment for benefits already paid. Failure to reimburse benefits previously advanced will be considered an unauthorized benefit overpayment.

If an unauthorized benefit payment has occurred, the Trust has the right to deduct the benefit overpayment from any future payments owed to the individual or others claiming eligibility through the same individual. If there is an outstanding unauthorized payment, the Trust, with notice to the individual, may prohibit the individual and any family members from enrolling in a Trust-provided HMO or insured option while the unauthorized benefit payment is outstanding.

To obtain an Agreement to Reimburse form, or for additional information, contact your Area Administrative Office.
Recovery of Unauthorized Benefit Payments

The Trust provides benefits only pursuant to the written terms of the Trust. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Trust, or if a participant or dependent fails to reimburse advanced benefits in response to an agreement to reimburse, the profiting individual will be obligated, upon notice from the Trust, to make restitution of the overpayment. If restitution is not made, the Trust will be entitled to bring an action to recover the overpayment from the profiting individual and, if misrepresentation is involved, from any individual or entity participating in the misrepresentation. In any such action the court may award the Trust its reasonable attorney fees and court costs in addition to the amount of the overpayment.

The Trust will also have the right to deduct the amount of a benefit overpayment from any future benefit payments owed to the individual or others claiming eligibility through the same individual.

Medical and Dental Consultants

The Board of Trustees has authorized the Area Administrative Offices to refer claims for medical, dental, or prescription drug benefits which involve difficult issues as to medical necessity, the nature, classification, scope or duration of care, and the qualification of providers to outside doctors, dentists, or other professionals for their review and advice, and to follow such advice in the adjudication of the referred claims. In determining the issues presented to them, the outside consultants may rely on their own expertise and on professional standards, procedures, and protocols to which they have access. Medical and dental consultants may also be used to determine usual, customary, and reasonable allowances for covered services.

Any claim denial which incorporates or is based upon medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust’s appeals procedures.

Interpretation of Trust Documents

The Board of Trustees may, in its discretion, adopt administrative rules, policy statements, procedures, or motions all for the purpose of insuring the efficient administration of the Trust and its benefit plans. The Board of Trustees reserves the authority and sole discretion to interpret and apply the provisions of the benefit plans and their administrative rules, policy statements, procedures, or motions.
Claims Filing and Claims Appeal Procedures

How to File a Claim

The claim filing requirements that normally apply to the various benefits provided by the Trust are outlined below. If a claim involves an accident or a potential third-party liability or workers’ compensation claim, the Trust may require additional information from you in order to process your claim.

<table>
<thead>
<tr>
<th>ADMINISTRATOR</th>
<th>HOW TO SUBMIT CLAIMS</th>
<th>SUBMIT CLAIMS TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Trust Medical</td>
<td>In most cases, providers will submit bills for payment. If they do not, request an itemized statement of services and charges and a diagnosis. Submit the claim with the Trust’s name, participant’s ID number and name of the person receiving services.</td>
<td>If you live in California, send any medical claims to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAYOR ID: 47198</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or to ANTHEM BLUE CROSS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 60007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Los Angeles, CA 90060</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you reside outside California, your claims should be submitted to your local Blue Cross and/or Blue Shield plan. To ensure prompt processing, include with your claim, the letters WUW, which is the three digit group number from your participant card. If you have questions about identifying your local Blue Cross and/or Blue Shield plan, call your Area Administrative Office.</td>
</tr>
<tr>
<td>Trust Medical</td>
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<tr>
<td>ADMINISTRATOR</td>
<td>HOW TO SUBMIT CLAIMS</td>
<td>SUBMIT CLAIMS TO</td>
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</tr>
<tr>
<td>Indemnity Trust Dental</td>
<td>In most cases, dental providers will submit bills for you. If they do not, request an itemized statement of services and charges with a diagnosis. Submit the claim with the Trust’s name, participant’s ID number and name of the person receiving the services.</td>
<td>Submit claims to your Area Administrative Office.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medco</td>
<td>Participating pharmacy retail purchases: no claim form required. Non-participating pharmacy purchases: no benefits are paid. Home delivery pharmacy purchases: no claim form required.</td>
<td></td>
</tr>
</tbody>
</table>
| Mental Health and Chemical Dependency| HMC/APS network providers: No claim form required. Non-HMC/APS providers: submit a CMS (HCFA)-1500 form (available from HMC/APS). Hospital claims are billed on a form UB92 form.                                                                                                                                  | HMC/APS  
P.O. Box 99  
Linthicum, MD 20910-0099                                                                 |
| Vision                              | For VSP providers: No claim form required. Non-VSP providers: Submit an itemized statement of charges, your name, and the participant’s ID number.                                                                                                                                                                         | VSP  
P.O. Box 997105  
Sacramento, CA 95899-7105                                                                                           |
| Life Insurance and AD&D             |                                                                                                                                                                                                                                                                                                                                                      | Call your Area Administrative Office                                                                 |
| Prudential                          | Submit a certified copy of the death certificate, social security numbers for the deceased and the beneficiary, and a Prudential claim form. If the insured died within the previous six months in the U.S. or Canada, the death certificate does not need to be certified. | Call your Area Administrative Office                                                                 |

VSP  
P.O. Box 997105  
Sacramento, CA 95899-7105
**One-Year Time Limit for Filing Claims**

For a claim to officially be considered a claim, you must request the Trust to provide benefits for a specific service or supply in accordance with the Trust’s reasonable claims filing procedures as described in this section. Except for urgent claims, which may be submitted orally, claims must be submitted in writing to the proper address. Claims must be submitted within one year from the date of receipt of the service or supply. Failure to submit a claim within this time frame or to request review of any action that has adversely affected you will result in a permanent denial of benefits (unless you can establish to the Trust’s satisfaction that it was not possible to file a claim within the one-year period). Different policy requirements exist for term life benefits and mental health and chemical dependency non-participating providers.

For any claim, the Trust may require additional information to process claims or meet Trust requirements, including inquiries related to eligibility, the nature of services or supplies provided, coordination of benefits, other insurance, third-party reimbursement requirements, or other Trust provisions. Failure to provide this required information may result in denial of the claim for benefits.

**Claims Review and Appeal Procedures**

If your appeal involves health or dental benefits through an HMO, you must contact that entity. Appeals involving mental health or chemical dependency benefits through Health Management Center must be pursued through HMC/APS. See the information on pages 64 to 65. Appeals involving vision benefits must be pursued through VSP. See the information on page 78. Claims involving eligibility under the Trust are subject to the claims appeal procedures set forth below.

In order to receive prompt payment for benefit claims, you must follow the proper claim filing procedures. Claims that are properly filed will be processed in accordance with the following guidelines:

**Post-Service Health and Weekly Time Loss Claims**

Post-service health claims are properly filed claims for medical, dental, prescription drug, or weekly time loss benefits that are not an urgent care or pre-service health claim as defined below. Under normal circumstances, you will be notified of the benefit determination for a post-service
health claim within 30 days of receipt of the claim. If additional information is needed to process the claim, you will be notified within 30 days of receipt of the claim and advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received, or (2) when 45 days have passed since the request for additional information was made.

**Pre-Service Health Claims**

Pre-service health claims are properly filed claims that must be pre-authorized to receive full benefits from the Trust. Currently inpatient hospital admissions must be pre-authorized.

Under normal circumstances, you will be notified of the benefit determination for a pre-service claim within 15 days of receipt of the claim. If additional information is needed to process the claim, you will be notified within 15 days and advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received, or (2) when 45 days have passed since the request for additional information was made.

If services that require pre-authorization have already been provided and the issue is what payment, if any, will be made, the Trust will process the claim as a post-service health claim.

**Urgent Care Health Claims**

Urgent care claims are claims or requests for services that must be decided more quickly because using the normal time frames for benefit determinations and appeals could seriously jeopardize the health of the individual or expose him or her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed orally or in writing by you, your beneficiary, or a health care provider (physician, osteopath, or licensed nurse practitioner) with knowledge of the patient’s medical condition.

Under normal circumstances, you will be notified of the benefit determination for an urgent care claim as soon as possible within 72 hours of receipt of the claim. If additional information is needed to process the claim, you will be notified within 24 hours and advised of the specific information required. A benefit determination will then be made no later than 48 hours after the earlier of (1) the date the Trust receives the additional information, or (2) 48 hours have passed since the request for additional information was made.

The Trust will treat a claim as urgent if any physician with knowledge of the patient’s medical condition deems the claim to involve urgent care. Otherwise, determinations regarding whether a claim is urgent will be made by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If services that constitute urgent care have already been provided and the issue is what payment, if any, will be made, the claim will be processed as a post-service claim.
Urgent claims involving mental health or chemical dependency benefits will be processed by HMC/APS under its own procedures. Contact HMC/APS for information regarding making claims of this nature.

**Concurrent Care Health Claims**

Concurrent care claims are those involving a decision to reduce or terminate an ongoing course of treatment, as well as decisions regarding requests by you to extend a course of treatment beyond what has been approved. You will be notified of any reduction or termination of a previously approved course of treatment prior to the date of the reduction or termination, allowing you sufficient time to appeal and obtain a determination on the appeal before the decision is to take effect.

If an urgent care claim is involved, any request by you to extend the course of treatment beyond the period of time or number of treatments previously approved will be decided as soon as reasonably possible. In any case, you will be notified of the determination within 24 hours of receipt of the request.

Any appeal of a decision involving a concurrent care claim will be treated as either a pre-service, urgent care, or post-service claim appeal, as appropriate under the circumstances.

**Life Insurance and AD&D Claims**

Life insurance and AD&D claims are processed by Prudential. For any properly filed claim for life insurance or AD&D benefits, Prudential will notify you of its claim determination within 45 days of receipt of the claim, and a written notice of the benefit determination will be sent to you. This time period can be extended by two 30-day periods if necessary, for reasons beyond the control of Prudential or the Trust.

**Notice of Denial of Benefits**

For all types of claims, a notice of denial of benefits will provide the following information:

- The reason for the denial.
- A reference to the plan provision relied on.
- A description of any additional material needed to perfect the claim.
- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature, or an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.
- An explanation of the Trust’s appeal procedures.

The denial will be mailed to you or your beneficiary at your last known address. For determinations involving urgent care, this information may be provided orally within the appropriate time frame.
How to Appeal a Benefit Denial

You will have 180 days from the date of denial to appeal an adverse benefit determination, except denials of life insurance and AD&D claims must be filed within 60 days. An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

You, your beneficiary, or an authorized representative must submit an appeal in writing, except that urgent care appeals may be submitted orally, to the Area Administrative Office or to the entity that made the denial. An appeal must identify:

• The benefit determination involved;
• The reasons for the appeal; and
• Any information you or your authorized representative believes is pertinent.

Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by you (or parent or legal guardian where appropriate) that identifies the representative and authorizes him or her to seek benefits for you. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within 180 days of the denial (or 60 days for life and AD&D claims) or 180 days of the Trust’s decision on an appeal will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

Appeal Procedures

The following procedures will be the exclusive procedures available to you or your beneficiary who is dissatisfied with an eligibility determination, benefit denial, partial benefit award, or any other adverse benefit determination by the Trust or its authorized claims payers. Appeals involving benefits provided through an HMO, mental health or chemical dependency services provided by HMC/APS, or vision services provided through VSP must use those entities’ appeal procedures. These procedures must be exhausted before you or your beneficiary may file suit under Section 502(a) of ERISA.

Information to be Provided on Request

You and/or your authorized representative may, on request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures, or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination.

If a decision is based upon a medical necessity determination, an explanation of that determination and its application to the individual’s medical circumstances will also be available upon request.
Review of Appeal

Claim appeals will be reviewed by the Trust’s Appeals Committee, which consists of at least one employer and one labor organization Trustee, except for life insurance and AD&D claims, which are reviewed by Prudential. A decision will be made within the following time limits:

- Post-Service and Weekly Disability Claims — an appeal will be presented to the Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following receipt of the appeal. The Appeals Committee will provide the claimant written notification of its decision within five days of the hearing. Notice for other types of claims is as follows:
  - Pre-Service Claim — within 30 days of receipt of appeal.
  - Urgent Care — within 72 hours of receipt of appeal if the initial claim is complete when submitted, or an additional 48 hours after receiving additional information if it is necessary to process the claim.
  - Life/AD&D — within 45 days of receipt of appeal, or an additional 45 days if special circumstances require an extension.

The Appeals Committee will review the administrative file that consists of all documents relevant to the claim. They will also review all additional information submitted by or on your or your beneficiary’s behalf. The review will be conducted without deference to the initial benefit determination.

If the denial is based on medical judgment, the Appeals Committee will receive a review by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who made the initial benefit determination nor a subordinate of that individual. The Appeals Committee may also have an individual with a different licensure review a matter if he or she is qualified to treat the condition involved. The Appeals Committee will identify by name any individuals consulted for medical or vocational advice.

In the case of urgent claims, information will be provided to the claimant or authorized representative via telephone, facsimile, or other expedited method.

Issuing a Decision

Following a hearing, the Appeals Committee will provide the claimant written notification of its decision within five days. Where appropriate, the Board of Trustees may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing.

The decision will include:

- The specific reasons for an adverse decision.
- A reference to the plan provision(s) involved.
- A statement that all information relevant to the claim is available free upon request.
• Notification of any internal rule or guideline or protocol relied on (or a statement that such information is available free of charge).
• If the decision was based on a medical judgment, an explanation of the medical judgment applying the terms of the plan to the claimant’s circumstances (or a statement that such information is available free of charge).
• A notice of the claimant’s rights under Section 502(a) of ERISA.

For life and AD&D claims, if the claim remains denied, you may submit a second appeal to Prudential within 180 days. A final decision will be made by a member of Prudential Claims Management who was not involved in the previous appeal. If your claim still remains denied and you make an appeal within 180 days, the third appeal will be reviewed by three members of Prudential Claims Management who were not involved in your previous appeals.

The Trust provides for no voluntary alternative dispute resolution procedures. If you or your beneficiary remain dissatisfied with the Trust’s determination after exhausting the claim appeal procedures, you have the right to pursue a civil action under 29 U.S.C. §1132(a) (i.e., Section 502(a) of ERISA).

Claims Appeal Procedures for HMOs or Insured Providers

If you are appealing benefits denied by an HMO with which the Trust contracts, or life and AD&D benefits through Prudential, you should follow the procedures outlined by that organization. Claims involving eligibility are subject to the Trust’s claims appeal procedures.

Exhaustion of Remedies/Limitations on Actions

No legal or equitable action for benefits under this Trust will be brought unless and until the claimant has, in accordance with the foregoing claims and appeal procedures:

• Submitted a written claim for benefits as required.
• Been notified that the claim is denied.
• Filed a written request for review.
• Been notified in writing of the decision of the Appeals Committee or the organization responsible for determining the type of benefit in question.

No legal or equitable action for benefits under this Trust may be commenced against the Trust more than 12 months after the issuance of an Appeals Committee’s written decision or the denial of the requested benefit if no appeal is made.
**Summary Plan Description and Other Information**

**Name of Plan**
Western Teamsters Welfare Trust Health and Welfare Plan for Active Regular and Casual Employees.

**Name, Address and Telephone Number of Plan Sponsor and Administrator**
This Plan is sponsored and administered by a joint labor-management Board of Trustees pursuant to an Agreement and Declaration of Trust. The name, address and telephone number of the Board of Trustees is:

Board of Trustees  
Western Teamsters Welfare Trust  
2323 Eastlake Avenue East  
Seattle, Washington 98102  
(206) 329-4900

**Name, Title and Principal Place of Business of Each Trustee**
See page 117 of this booklet.

**Identification Numbers**
Employer Identification Number: 91-6033601  
Plan Number: 501

**Type of Plan**
This Plan is a health and welfare plan providing medical, prescription drug, mental health and chemical dependency, dental, vision, weekly time loss, life, and accidental death and dismemberment benefits.

**Type of Administration**
This Plan is administered by the Board of Trustees with the assistance of contract administrative organizations which provide a Principal Trust Office and Area Administrative Offices, and other providers of services. The names and addresses of the contract administrative organizations are shown on page 118 of this booklet. For general information about the Plan, contact your Area Administrative Office.
Name and Address of Agent for Service of Legal Process

The agent for service of legal process is:

Western Teamsters Welfare Trust
Administrative Manager
Principal Trust Office - Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

In addition, service of legal process on the Plan may be served on any member of the Board of Trustees at the Principal Trust Office or at his or her address listed on page 117.

Source of Contributions — Collective Bargaining Agreements

This Plan is maintained by local unions affiliated with the Teamsters Union and employers who are parties to collective bargaining agreements requiring contributions to the Western Teamsters Welfare Trust. These agreements generally provide that the employers who are parties thereto will make monthly contributions to the Western Teamsters Welfare Trust for the purpose of enabling eligible employees working under such agreements to participate in the Western Teamsters Welfare Trust. The contribution rates and the job classifications covered are specified in such agreements. The Plan is funded by these employer contributions (certain employees whose coverage would otherwise terminate may continue coverage for a limited period of time by making the required self-payments).

A copy of each of the applicable collective bargaining agreements is available for examination, without charge, by participants and beneficiaries, at the Area Administrative Offices. A copy of any of these documents may be obtained by participants and beneficiaries upon written request addressed to the Board of Trustees of the Western Teamsters Welfare Trust at the Principal Trust Office, 2323 Eastlake Avenue East, Seattle, Washington 98102. The Trust will make a reasonable charge for providing copies of any documents requested.

Information on whether a particular employer or union is making contributions, and if so, the address of the employer or union, may be obtained by participants and beneficiaries without charge upon written request addressed to the Board of Trustees at the Principal Trust Office.

Eligibility for Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes such contributions to the Trust. The eligibility rules that describe the requirements under which employees and their dependents become and remain eligible for benefits under this Plan are set forth on pages 4 to 10 of this booklet.
Circumstances That May Result in Ineligibility or Denial of Benefits

The rules describing the conditions under which the eligibility of employees and their dependents will terminate are on page 10 of this booklet.

This booklet also describes circumstances under which benefits may be reduced or denied, including descriptions of applicable limitations and exclusions. See the sections that describe particular benefit coverages as well as the specific and general exclusions.

The Board of Trustees has the authority to modify or terminate the benefits, in whole or in part, should financial circumstances so require.

Claims Appeal Procedures

The procedures for presenting denied claims for review are set forth on pages 96 to 103.

Plan Year

The plan year for this Plan is a 12-month period beginning September 1 and ending the following August 31, and is the fiscal year of the Plan for the purpose of accounting and reporting to the U.S. Department of Labor and other regulatory bodies.

Funding Mechanism

The Trustees provide benefits to the extent monies are currently available to pay the costs of such benefits. Benefits are available on a month-to-month basis and are not guaranteed to continue indefinitely.

<table>
<thead>
<tr>
<th>TYPE OF BENEFIT</th>
<th>TYPE OF FUNDING</th>
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<tbody>
<tr>
<td>Medical</td>
<td>The Indemnity Medical benefits are self-funded. Premiums are paid to the health</td>
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<td>maintenance organizations (HMOs) listed below, to provide medical benefits to</td>
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<td>participants that elect to participate in these plans:</td>
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<td></td>
<td>Group Health</td>
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<td></td>
<td>Intermountain Health Care (Select Med)</td>
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<td>Kaiser Foundation Health Plan of California</td>
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<td>Kaiser Foundation Health Plan of Colorado</td>
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<td>Kaiser Foundation Health Plan of Oregon</td>
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<td>Lovelace Health Plan</td>
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<td>PacifiCare of Arizona</td>
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<td>PacifiCare of California</td>
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<td>PacifiCare of Colorado</td>
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<td>PacifiCare of Nevada</td>
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<td>PacifiCare of Oregon</td>
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<tr>
<td></td>
<td>Presbyterian Health Plan</td>
</tr>
<tr>
<td>TYPE OF BENEFIT</td>
<td>TYPE OF FUNDING</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Indemnity prescription drug benefits are administered by Medco Health and are self-funded.</td>
</tr>
<tr>
<td>Managed Mental Health and Chemical Dependency Services</td>
<td>Mental health and chemical dependency benefits (with the exception of the EAP benefit) are self-funded. The EAP benefit is insured by HMC/APS.</td>
</tr>
<tr>
<td>Dental</td>
<td>Indemnity dental benefits are self-funded. Premiums are paid to the alternate dental care providers listed below to provide dental benefits to participants that elect to participate in these plans: Kaiser Foundation Health Plan of Oregon Safeguard Dental</td>
</tr>
<tr>
<td>Vision</td>
<td>Premiums are paid to Vision Service Plan to provide vision benefits.</td>
</tr>
<tr>
<td>Life and Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Premiums are paid to Prudential Insurance Company of America for Life and AD&amp;D benefits.</td>
</tr>
<tr>
<td>Weekly Time Loss Benefits</td>
<td>Weekly Time Loss Benefits are self-funded.</td>
</tr>
</tbody>
</table>

**Future of the Plan and Trust Fund**

The Western Teamsters Welfare Trust is expected to remain in full force and effect until terminated by action of the Trustees. The Trust will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust. In the event of termination, the Trustees will:

- Make provision out of the Trust for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination.
- Distribute the balance, if any, of the remaining assets of the Trust in such manner as they determine will carry out the purposes of the Trust, including, but not limited to, the providing of existing benefits on a pro-rata basis or the transfer of such funds to a successor trust having the same or similar purposes for the benefit of employees.
- Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship.

Upon termination, the Board of Trustees may transfer the remaining Trust assets, or any portion thereof, to the Trustees of any fund established for the purpose of providing substantially the same or greater benefits than those contemplated by this Plan. In no event shall any of the funds revert to or be recoverable by any employee, employer, or union.

Unless terminated sooner, this Trust will terminate upon the death of the last survivor of the persons entitled to benefits hereunder; provided, however, that if, as and when this Trust without the benefit of this provision will not violate the rule against perpetuities, then this provision will be of no force or effect, and this Trust will continue in perpetuity unless otherwise terminated.
Newborns’ and Mothers’ Health Protection Act of 1996

Group Health plans and health insurance issuers generally may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for you or your newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours if applicable).

Certificate of Health Coverage

Under the Health Insurance Portability and Accountability Act (HIPAA), if your coverage under this Plan stops, you and your covered dependents will receive a certificate that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan, if it excludes coverage for certain medical conditions which exist before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that exist before you enroll. You and your dependents may also request additional certificates within 24 months of losing coverage under this Plan. Such request should be made to your Area Administrative Office.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants be entitled to the following rights:

Right to Receive Information about Your Plan and Benefits

- You can examine without charge, at the Principal Trust Office, all documents governing the Plan. This includes insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- By submitting a written request to the Area Administrative Office, you can obtain copies of documents governing the operation of the Plan and an updated summary plan description. The Plan Administrator may charge you a reasonable fee for the copies.
- You should receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to provide a copy of this summary financial report to each Plan participant.

Right to Continue Group Health Plan Coverage

- You can continue health care coverage for yourself, your spouse, and/or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For more details, see COBRA Continuation Coverage and the documents governing Plan rules for COBRA continuation coverage rights.
Right to Reduce or Eliminate Exclusionary Periods

When your coverage under a group health plan ends, your Area Administrative Office or health insurance carrier should provide you with a certificate of creditable coverage. This certificate will prove to your new employer or new plan that you had coverage. If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions when you enroll in a new group health plan. Your group health plan administrator or health insurance carrier should provide a certificate of creditable coverage, free of charge, when:

- You lose coverage under the Plan.
- You become entitled to elect COBRA continuation coverage.
- Your COBRA continuation coverage ceases.
- You request a certificate of creditable coverage before losing coverage.
- You request a certificate of creditable coverage up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage (18 months if you enrolled late).

Right to Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of this employee benefit plan. These people, called “fiduciaries” of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Right to Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- Know why this was done.
- Obtain copies of documents relating to the decision, without charge.
- Appeal any denial.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request, in writing, a copy of plan documents or the latest annual report from the Plan and do not receive copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control.

You may file a suit in state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part.
You may file a suit in a federal court if you disagree with the Plan’s decision (or lack thereof) about whether or not a domestic relations order or a medical child support order is qualified.

You may seek assistance from the U.S. Department of Labor or file suit in a federal court if:

- Plan fiduciaries misuse the Plan’s money, or
- You are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

**Your Right to Assistance with Questions**

If you have any questions about this Plan, contact your Area Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at (866) 444-EBSA, or by downloading them from the Internal Revenue Website at [www.irs.gov](http://www.irs.gov).

**NOTICE OF PRIVACY PRACTICES**

Pursuant to regulations issued by the federal government, the Western Teamsters Welfare Trust is providing you this notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information. This notice is also available at the Trust’s website: [www.westernteamsters.com](http://www.westernteamsters.com).

**Use and Disclosure of Health Information**

Your health information may be used and disclosed without an authorization in the following situations:

**To Make or Obtain Payment.** The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.
To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves providing, coordinating, or managing health care or related services. For example, the Trust may disclose the name of your treating physician to another physician so that the physician may ask for your x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust’s participants. Health care operations include: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew, or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing, or credentialing activities).

For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information which summarizes participants’ claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

Disclosure Where Required by Law. In addition, the Trust will disclose your health information where applicable law requires. This includes:

a. In Connection With Judicial and Administrative Proceedings

The Trust will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection, and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure.
For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.

b. **When Legally Required for Law Enforcement Purposes**

The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries pursuant to court issued legal process, or a grand jury subpoena, or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose, and de-identified information cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness, or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises.

For example, the Trust could upon request of a law enforcement agency, provide information concerning the address of a fugitive.

c. **To Conduct Public Health and Health Oversight Activities**

The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect, or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

d. **In the Event of a Serious Threat to Health or Safety**

The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

e. **For Specified Government Functions**

In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.


f. For Workers’ Compensation

The Trust may release your health information to the extent necessary to comply with laws related to workers’ compensation or similar programs.

g. To a Personal Representative

The Trust may disclose your health information to an individual who is authorized by you or applicable law to serve as your personal representative.

Authorization to Use or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization. Generally, you will need to submit an authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional’s separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis, and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust’s disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal, or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs, and postage, if applicable, associated with your request.
Right to Receive Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust’s Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request may also be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust’s records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. If this Notice is modified you will be mailed a new copy.

Privacy Contact Person/Privacy Official. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

<table>
<thead>
<tr>
<th>PRIVACY CONTACT PERSON</th>
<th>PRIVACY OFFICIAL</th>
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<tbody>
<tr>
<td>Bob Kromm</td>
<td>Vice-President of Trust Administration</td>
</tr>
<tr>
<td>WTWT Account Executive</td>
<td>c/o Charlene Lind</td>
</tr>
<tr>
<td>Northwest Administrators, Inc.</td>
<td>Northwest Administrators, Inc.</td>
</tr>
<tr>
<td>2323 Eastlake Avenue E.</td>
<td>2323 Eastlake Avenue E.</td>
</tr>
<tr>
<td>Seattle, WA 98102</td>
<td>Seattle, WA 98102</td>
</tr>
<tr>
<td>Phone: (206) 726-3251</td>
<td>Phone: (206) 726-3281</td>
</tr>
<tr>
<td>Email: <a href="mailto:bkromm@nwadmin.com">bkromm@nwadmin.com</a></td>
<td>Email: <a href="mailto:clind@nwadmin.com">clind@nwadmin.com</a></td>
</tr>
</tbody>
</table>
**DUTIES OF THE TRUST**

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice summarizing its privacy practices and duties. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

**EFFECTIVE DATE**

This Notice and the rights it describes are effective April 14, 2003.

**MEDICARE PART D NOTICE**

Please read this Notice carefully and keep it where you can find it. This Notice contains information about your current prescription drug coverage with the Western Teamsters Welfare Trust (“Trust”) and prescription drug coverage available for participants who have enrolled in Medicare Part D. This Notice also informs you where to find additional information to help you make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Trust has determined that the prescription drug coverage it currently offers is, on average for all Plan participants, expected to pay out as much as or more than the standard Medicare prescription drug plan will pay, i.e., it is equivalent on a gross basis to Medicare Part D coverage. The Trust is, therefore, providing creditable prescription drug coverage. Read this Notice carefully – it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. Please note you are not required to enroll in Medicare Part D coverage since the Trust is providing creditable coverage.

Because your existing coverage through the Trust is on average expected to pay out as much as or more than the standard Medicare prescription drug plan, you can keep your coverage through the Trust and not pay extra if you later decide to enroll in Medicare Part D coverage.
Participants can enroll in a Medicare prescription drug plan when they first become eligible and each year from November 15 through December 31. Medicare beneficiaries leaving coverage through the Trust may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

Before you decide to enroll in a Medicare prescription drug plan, you should closely compare your current coverage, including which drugs are covered through the Trust, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Please be advised that if you enroll in a Medicare prescription drug plan, you will have to pay an annual premium, an annual deductible, and a percentage of your prescription drug expenses.

You should also know that if you drop or lose your prescription drug coverage through the Trust, and you do not enroll in Medicare prescription drug coverage after your current coverage ends, you may have to pay more to enroll in Medicare prescription drug coverage later. If you go for 63 days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your monthly Medicare Part D premium will increase at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you are enrolled in Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll.

For more information about this Notice or your current prescription drug coverage, please contact the Trust Office at (206) 329-4900. You will receive this Notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage or if prescription drug coverage through the Trust changes. You may also request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also obtain additional information about Medicare prescription drug plans from the following:

- www.medicare.gov.
- Your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- 1-800-MEDICARE (1-800-633-4227); TTY (1-877-486-2048).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Notice. If you enroll in one of the new plans approved by Medicare, which offers prescription drug coverage, you may be required to provide a copy of this Notice when you enroll to show that you are not required to pay a higher premium amount for coverage.
# Board of Trustees

<table>
<thead>
<tr>
<th>Employer Trustees</th>
<th>Union Trustees</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Coulson</td>
<td>Buck Holliday</td>
</tr>
<tr>
<td>9279 Silver Star Ave.</td>
<td>Teamsters Local 690</td>
</tr>
<tr>
<td>Desert Hot Springs, CA 92240</td>
<td>1912 N. Division</td>
</tr>
<tr>
<td></td>
<td>Spokane, WA 99207</td>
</tr>
<tr>
<td>A.J. Phillips</td>
<td>Randy Cammack</td>
</tr>
<tr>
<td>6715 Highland Park Drive</td>
<td>Teamsters Local 63</td>
</tr>
<tr>
<td>Fort Smith, AR 72916</td>
<td>845 Oak Park Road</td>
</tr>
<tr>
<td></td>
<td>Covina, CA 91724</td>
</tr>
<tr>
<td>Jim Roberts</td>
<td>Jim Santangelo</td>
</tr>
<tr>
<td>5351 Vista Lejana Ln.</td>
<td>Teamster Joint Council #42</td>
</tr>
<tr>
<td>La Canada, CA 91011</td>
<td>818 Oak Park Road</td>
</tr>
<tr>
<td></td>
<td>Covina, CA 91724</td>
</tr>
<tr>
<td>William R. Davidson</td>
<td>Joe Silva</td>
</tr>
<tr>
<td>Roadway Express</td>
<td>Teamsters Local 70</td>
</tr>
<tr>
<td>202 Winding River Road</td>
<td>400 Roland Way</td>
</tr>
<tr>
<td>Eatonton, GA 31024</td>
<td>Oakland, CA 94621-2012</td>
</tr>
<tr>
<td></td>
<td>Walter Maestas</td>
</tr>
<tr>
<td></td>
<td>Teamsters Local 492</td>
</tr>
<tr>
<td></td>
<td>4269 Balloon Park Rd. NE</td>
</tr>
<tr>
<td></td>
<td>Albuquerque, NM 87109</td>
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</table>
WTWT AREA ADMINISTRATIVE OFFICES

Check with the Principal Trust Office to determine the proper Area Administrative Office for you to file claims or make inquiry regarding the Plan.

**Principal Trust Office**
Northwest Administrators
2323 Eastlake Avenue East
Seattle, WA 98102
(206) 726-3235

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>AREA ADMINISTRATIVE OFFICE</th>
</tr>
</thead>
</table>
| Washington, Oregon, Idaho, Utah, Colorado, Wyoming, Northern California, and Northern Nevada | Northwest Administrators  
2323 Eastlake Avenue East  
Seattle, WA 98102  
(206) 726-3235  
Toll free: (800) 872-5439 |
| Southern California, Southern Nevada, Arizona, and New Mexico | Southwest Administrators  
P.O. Box 1121  
Alhambra, CA 91802-1121  
or  
1000 South Fremont Avenue, A-9 West  
Alhambra, CA 91803-4337  
(626) 284-4792  
Toll free: (877) 350-4792 |
| Montana | William C. Earhart Company, Inc.  
P.O. Box 4148  
3140 Northeast Broadway  
Portland, OR 97208  
(503) 282-5581  
Toll free: (800) 547-1314 |
| Change of Operations Participants | Southwest Administrators  
P.O. Box 1130  
Alhambra, CA 91802-1130  
or  
1000 South Fremont Avenue, A-9 West  
Alhambra, CA 91803-4337  
Toll free: (800) 472-5340 |
**Western Teamsters Welfare Trust for Active and Casual Employees Important Contact INFORMATION**

<table>
<thead>
<tr>
<th>IF YOU HAVE QUESTIONS OR NEED TO CONTACT</th>
<th>TELEPHONE NUMBERS/ONLINE ADDRESSES</th>
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<tbody>
<tr>
<td><strong>Area Administrative Offices</strong></td>
<td></td>
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<tr>
<td>Principal Trust Office</td>
<td>Northwest Administrators at 206-726-3235</td>
</tr>
<tr>
<td>Montana</td>
<td>William C. Earhart Co. at 503-282-5581 or 800-547-1314</td>
</tr>
<tr>
<td>Arizona, New Mexico, S. California, and S. Nevada</td>
<td>Southwest Administrators at 626-284-4792 or 877-350-4792</td>
</tr>
<tr>
<td>Change of Operations Participants</td>
<td>Southwest Administrators at 626-284-4792 or 877-350-4792</td>
</tr>
<tr>
<td><strong>Care Management Program</strong></td>
<td></td>
</tr>
<tr>
<td>For Hospital Utilization Review and Pre-authorization</td>
<td>Anthem 800-274-7767</td>
</tr>
<tr>
<td>For Medical Case Management</td>
<td></td>
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<tr>
<td><strong>PPO Network</strong></td>
<td></td>
</tr>
<tr>
<td>To locate a preferred provider or a preferred provider directory</td>
<td>Your Area Administrative Office or online at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> if you live in California or <a href="http://www.bluecares.com">www.bluecares.com</a> (go to “Blue Finder” then click on “Doctor Finder”) if you live outside California</td>
</tr>
<tr>
<td><strong>Indemnity Medical Claims</strong></td>
<td></td>
</tr>
<tr>
<td>For submission of Indemnity Medical Claims</td>
<td>If you live in California, submit to Payor I.D. 47198 or Anthem BlueCross, P.O. Box 60007, Los Angeles, California 90060. If you live outside California, claims should be submitted to your local BlueCross and/or BlueShield plan.</td>
</tr>
<tr>
<td><strong>Mental Health and Chemical Dependency Benefit Plan</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital admissions</td>
<td>Health Management Concepts, Inc. (HMC/APS) 866-521-0086 or <a href="http://www.apshealthcare.com">www.apshealthcare.com</a></td>
</tr>
<tr>
<td>To arrange for outpatient treatment</td>
<td></td>
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<tr>
<td><strong>Prescription Drug Benefit Plan</strong></td>
<td></td>
</tr>
<tr>
<td>To locate a Medco retail pharmacy</td>
<td>Medco Health 800-711-0927 (800-759-1089 TTY) or <a href="http://www.medco.com">www.medco.com</a></td>
</tr>
<tr>
<td>Home Delivery Pharmacy Service</td>
<td></td>
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</table>
Dental, Time Loss, Life and AD&D Claims and Plan Administration

Dental Plan Benefits or Claims
Time Loss Benefits or Claims, Life and AD&D Claims
Eligibility
ID Cards
Your Area Administrative Office
Call the Principal Trust Office to determine the proper Area Administrative Office for you to file claims or make an inquiry about the Plan
www.westernteamsters.com

Vision Benefit Plan
To locate a VSP network doctor
For vision benefit information
VSP
800-877-7195
www.vsp.com

HMO Plans
Group Health
Intermountain Health Care (Select Med)
Kaiser Foundation Health Plan of California
Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Oregon (includes Southwest Washington)
Lovelace Health Plan
PacifiCare of Arizona
PacifiCare of California
PacifiCare of Colorado
PacifiCare of Nevada
PacifiCare of Oregon
Presbyterian Health Plan
206-901-4636 or 888-901-4636
www.ghc.org
800-538-5038
www.selecthealth.org
800-464-4000
www.kaiserpermanente.org
303-338-3800 Denver/Boulder
888-681-7878 Colorado Springs
www.kaiserpermanente.org
503-813-2000 Portland
800-813-2000
www.kaiserpermanente.org
505-262-7363 or 800-808-7363
www.lovelacehealthplan.com
800-347-8600
www.pacificare.com
800-624-8822
www.pacificare.com
800-877-9777
www.pacificare.com
800-347-8600
www.pacificare.com
800-932-3004
www.pacificare.com
505-923-5678 or 800-356-2219
www.phs.org
Alternate Dental Plans
Kaiser Foundation Health Plan of Oregon  800-813-2000
(Oregon and Southwest Washington)  www.kp.org/nw

Safeguard Dental  800-880-1800
www.safeguard.net