TEAMSTERS BENEFIT TRUST

GUIDE TO YOUR BENEFITS

COMPREHENSIVE RETIREE PLAN

REVISED MAY 2009

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INTRODUCTION

This *Guide to Your Benefits* explains how you become eligible for coverage, how to make or appeal a benefit claim and your rights under federal benefits and privacy laws. Your *Summary of Coverage* explains the specific benefit provisions and limitations that apply to your TBT Plan.

This guide, along with the *Summary of Coverage* and *Comparison of Medical Benefits* (all contained in the green folder with the heading *Your Benefits Package*), is technically known as a *Summary Plan Description*. Together, these materials are intended to provide the information you will need to use the *Comprehensive Retiree Plan* (which is referred to in the rest of this guide as "the CRP" or "the Plan").

If you choose medical coverage through an HMO available under the Plan, an enrollment and information packet is sent to you containing the HMO's *Evidence of Coverage*.

You'll be sent a *Plan Change Notice* or written update (officially known as *a Summary of Material Modifications*) from time to time when changes are made to the Plan. Be sure to read these announcements and keep them in the folder pocket with your other Plan materials.

Information about Plan administration and your legal rights under the Employee Retirement Income Security Act (ERISA) may be found on pages 39-42.

Refer to your *Summary of Coverage* for other details you need to know (such as the amounts of your deductibles, copayments and benefit maximums). If you have questions, contact the TBT Plan Administration Office at the numbers shown at right. When calling, you'll be asked for the name of your TBT Plan (the Comprehensive Retiree Plan or CRP) and your Social Security number.

NOTICIA EN ESPAÑOL

Este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo el Plan de TBT. Si usted tiene dificultad en entender alguna parte de este folleto, o necesita mas información comuniquese con la Oficina de Administracion del Plan TBT a el domicilio localisado abajo en esta pagina. Horas de oficina: 8:00 a.m. a 5:00 p.m. P.S.T., Lunes a Viernes (excepto dias festivos). Horas de Servicio al Cliente: 8:30 a.m. a 5:00 p.m. P.S.T., Lunes a Viernes (excepto dias festivos). El numero de telefono es (510) 796-4676 o (800) 533-0119.

Questions?

If you have questions about the Plan or eligibility that are not addressed in this guide, contact:

Teamsters Benefit Trust (TBT)
TBT Plan Administration Office

Mailing Address

P.O. Box 5820
Fremont, CA 94537-5820

Office Address

39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Internet Web Site

www.tbtfund.org

Customer Service Telephone Hours

8:30 a.m. to 5:00 p.m. P.S.T.
Monday - Friday (except holidays)
(510) 796-4676 or (800) 533-0119

Office Hours

8:00 a.m. to 5:00 p.m. P.S.T,
Monday - Friday (except holidays)

Fax Number

(510) 795-0680

Note: Do not send claims by fax, unless the TBT Plan Administration Office requests that you do so. Original claim forms and documentation are required.

Teamsters Benefit Trust (TBT)

Board of Trustees

Formed as a result of collective bargaining between labor and management, your Plan is under the direct management of a joint Board of Trustees, composed of Union and Employer members.

The current Trustees are listed on page 39 and in your most recent *Summary of Coverage*. The Board of Trustees has sole authority to interpret Plan provisions and to make decisions about the Teamsters Benefit Trust and the Plans that TBT sponsors. No individual Trustee, Union or Employer representative may interpret the Plan or act as an agent of the Board of Trustees. Only the TBT Plan Administration Office represents the Trustees in verifying eligibility, administering benefits and providing information and may give you information in person, on the phone or in writing. However, only written communications from the TBT Plan Administration Office on behalf of the Board of Trustees are binding upon the Board of Trustees.

The Board of Trustees has the power to amend or terminate the Plan at any time. This *Summary Plan Description* does not guarantee future benefits in any way.

If you wish, you may write to the Board of Trustees in care of the TBT Plan Administration Office. The address is printed on the previous page.

ARE YOU MOVING?

Whenever you move, send the enclosed ***Change of Address Form*** *to the TBT Plan Administration Office so you'll receive important information about your benefits. If you want to verify your address or other data, contact the TBT Plan Administration Office. The TBT address and phone numbers are listed on the previous page.*

Update Your Records

Have you recently been married, widowed or divorced or had other important changes? It is your responsibility to notify the TBT Plan Administration Office in writing within 60 days about changes that may affect eligibility.

Marriage Changes. Changes in marriage status must be received in writing by the TBT Plan Administration Office within 60 days. (See *Change in Marriage Status* on page 9.) Provide the names, Social Security numbers and dates of birth for you and your covered spouse—along with a copy of the marriage certificate (if married), the divorce decree (if divorced) or your spouse's death certificate (if widowed). See page 4 for an explanation of the Plan's domestic partner coverage and notice requirements.

Address Changes. Notices of any material changes to the Plan are sent to the current address on file with the TBT Plan Administration Office.

Keep your address current, so you'll receive up-to-date information about your benefits. Remember, TBT keeps one address for each participant. If your spouse does not live with you, make sure he or she knows that *all TBT mail is sent to your address*.

COVERAGE IS NOT AUTOMATIC

If you don't enroll within 30 days after you and your covered spouse become eligible, coverage may be delayed—or even denied if you choose an HMO. You can also lose the opportunity to enroll in the TBT medical options of your choice. See ***How to Enroll*** *on page 6.*

Retiree Eligibility Rules

You qualify for the Comprehensive Retiree Plan (CRP) if you meet *all* of the following eligibility rules:

1. You are a pensioner with the Western Conference of Teamsters Pension Plan (or another plan approved by TBT) or a recipient of Social Security disability benefits.

RETIREMENT DATE

The date your retirement is effective (your "retirement date") as determined by the Western Conference of Teamsters Pension Plan (or another TBT-approved Plan).

2. You were covered under TBT Plan I, I-85, I-A, III, III-A, III-NEWS, IV, V, V-A, V-A-NEWS or VI (or other plans approved by TBT) for at least 24 out of the 36 months immediately before the date you retire from active employment. *For purposes of this eligibility requirement, "coverage" includes active coverage under any predecessor plan that merged into TBT or months during which you self-pay for coverage in your active employee plan.*
3. You are not currently covered by or eligible for a group health plan for active employees (except as noted under the Exceptions on this page).
4. You make timely self-payment in the amount required by the Plan, as determined by the TBT Board of Trustees.
5. You have no gap in coverage between eligibility as an active employee covered under a TBT Plan (see item 2 above) and eligibility as a retiree, except as noted under the Exceptions on this page.

EXCEPTIONS

Disability

If you retire due to disability, a gap in coverage beyond the 12-month enrollment period will be waived as long as you apply for coverage in a timely manner after you receive notice of entitlement from Social Security or the Western Conference of Teamsters Pension Plan (or another TBT-approved plan).

Employer-Paid Health Plan

If you retire from a participating Employer and meet all other qualifications for CRP eligibility, but accept employment from another employer providing an employer-paid health plan, you may postpone enrollment in the CRP. ***However, you must enroll in the CRP (if you qualify) no later than 60 days after the loss of employer-paid health plan coverage. If you do not enroll within 60 days, you will not be permitted to enroll at a future date.*** *You may also postpone CRP enrollment if you are covered under your spouse's employer-paid health plan under the same conditions.* ***Note:*** *You must apply: 1) for postponed enrollment, submit a written request with proof of employer-paid health plan coverage, and 2) when you lose employer-paid health plan coverage and want to reenroll, you must submit a written request for CRP enrollment and provide proof of uninterrupted employer-paid coverage. There may be no gap in coverage between your eligibility under the active employer group health plan (TBT or non-TBT) and your eligibility as a retiree. See* ***Temporary Suspension of Coverage*** *on page 3.*

6. Timely Enrollment Requirement: You must submit an *Application for Retiree Benefits* and a copy of your Social Security or pension certification to the TBT Plan Administration Office within 12 months from when you first become eligible for TBT retiree benefits and within 30 days of the date you want retiree coverage to begin. If you do not enroll within this 12-month period, except as noted under the Exceptions on this page, you are not permitted to enroll at a future date (see *When Your Coverage Begins* on page 5 and *How to Enroll* on page 6).

REMINDER

All required enrollment forms (including HMO applications) must be received by the TBT Plan Administration Office before coverage begins. (See pages 5-8 for enrollment details.)

COBRA Exception

If you elect COBRA continuation coverage after you lose eligibility as an active employee, you may apply for Retiree Plan enrollment when your COBRA coverage ends.

Temporary Suspension of Coverage

Once you enroll in the CRP, you may temporarily suspend coverage during any period that you subsequently become covered under an employer-paid health plan through your own employment or as a dependent through your spouse's employment. The same requirements and conditions stated under *Employer-Paid Health Plan* (in the green box on page 2) apply to a temporary suspension and reinstatement of coverage.

Coverage Effective Date (Delayed Enrollment or Temporary Suspension of Coverage)

If there is an approved gap between eligibility as an active employee and enrollment as a retiree or if you temporarily suspend retiree coverage, the effective date of enrollment or reinstatement shall be the first day of the month following receipt of your request for such action and submission of the required self-pay contributions and all required enrollment forms. No claims incurred before your effective date will be paid. **Note:** A written request for reinstatement or delayed enrollment must include proof of uninterrupted employer-paid group health plan coverage.

Dependent Eligibility Rules

The only person eligible for dependent coverage under this Plan is your legal spouse (or domestic partner as explained on page 4). Children are not eligible. If you have children who were formerly covered as your dependents under your plan for active employees, contact the TBT Plan Administration Office for information about COBRA continuation coverage or alternate coverage outside of TBT.

If your medical coverage as an active employee was through an HMO, you may also contact the HMO for information concerning conversion of your dependent's coverage to an individual plan provided by the HMO. This plan may cost more and provide fewer benefits than group coverage.

Spouse's Eligibility

(See *When Coverage Begins for Your Spouse* on pages 5-6.)

1. Your spouse is eligible for self-payment coverage under the Plan as long as he or she is married to you under a legally valid marriage.
2. If you are married when you enroll in the Plan and intend to cover your spouse, your spouse's coverage cannot begin until you declare him or her as your covered dependent on your TBT *Retiree Enrollment Form* when you enroll and pay the required monthly contributions. (Your spouse must be enrolled in the same medical option you choose for yourself.)

   If, however, when you first become eligible to enroll, your spouse is covered under an employer-sponsored group medical plan or COBRA (see *COBRA Exception* on page 2), you may add your spouse to the Plan at a later date—as long as you do so within 60 days of the date when your spouse's employer-paid medical coverage or COBRA coverage ends. **Note:** A written request for postponed enrollment and proof of Employer-paid coverage are required to suspend coverage. Proof of your spouse's uninterrupted coverage is also required at the time of the delayed enrollment. See *Employer-Paid Health Plan* on page 2.

   Except as described above, if you do not enroll your spouse when you enroll, your spouse will not be eligible for coverage at any time in the future.
3. If you marry *after* you enroll in the Plan, your spouse becomes eligible for coverage on your marriage date. You may add your spouse at that time by sending in a completed *TBT Retiree Enrollment Form*, a copy of your marriage certificate and the required self-payment for your spouse within 60 days of your marriage date. *If you don't add your spouse within 60 days, your spouse will not be eligible for coverage at any time in the future.*

   You should phone or write the TBT Plan Administration Office within 60 days after your marriage date or coverage may be delayed—especially if you are covered under an HMO. Once you notify the TBT Plan Administration Office, all enrollment materials will be mailed to you, including a new *TBT Retiree Enrollment Form* (and HMO *Change of Status Form* if you are covered under an HMO).
4. In the event of your death after enrollment in the CRP, your surviving spouse may continue coverage by self-payment. If you die before you complete timely enrollment in the Plan, your surviving spouse may apply for CRP coverage as long as you were fully eligible to participate in the Plan at the time of your death and all the required application forms, eligibility documents and self-payments are received within 60 days after your death.
5. Your surviving spouse may not add a dependent (new spouse) to the Plan.
6. If you are legally married to a same-sex spouse, you may have to report as taxable income the value of the benefits received by your same-sex spouse.

Domestic Partners

If your former participating Employer is required by local ordinance or state law to provide coverage to domestic partners, the CRP covers a domestic partner in the same way that it covers a legal spouse, except that you may have to report as taxable income the value of the benefits received by your domestic partner.

Domestic Partnership Coverage

Below is a summary of the Plan's domestic partner coverage requirements:

If you are age 62 or younger, you and your domestic partner must be the same gender; but if you are over age 62, you can enroll for coverage as a domestic partner of the opposite gender. (See *Exception* to the right.)

In addition, you and your domestic partner must otherwise meet the requirements for domestic partnership under California law, including:

- You and your domestic partner are each other's sole domestic partner.
- Neither of you is married to or legally separated from another person.
- You and your domestic partner are more than 18 years old.
- You and your domestic partner are capable of consenting to the domestic partnership.
- You and your domestic partner share a common residence.
- Neither you nor your domestic partner has previously filed a *Declaration of Domestic Partnership* with someone other than your current domestic partner that has not since been terminated.
- You and your domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the State of California.
- You and your domestic partner are jointly responsible for each other's basic living expenses incurred during your domestic partnership.
- You and your domestic partner filed a *Declaration of Domestic Partnership* with the Secretary of State of California.

Exception: If your former Employer is required by a local law or municipal ordinance to recognize opposite-sex domestic partnerships regardless of age, your opposite sex-domestic partner is eligible for domestic partner coverage. You must still meet all of the above requirements for domestic partnership, except the age requirement and the *California Certification* requirement. Without *California Certification*, you will be required to produce the municipality's certification of domestic partnership form. Before you may enroll your opposite-sex domestic partner, you must provide to the TBT Plan Administration Office a signed statement from your employer indicating that it is required to comply with such a local rule or ordinance. You can obtain a form for this purpose from the TBT Plan Administration Office.

Note: *TBT will recognize legal domestic partnerships under the laws of states other than California. Generally, you and your domestic partner must comply with all requirements of the state law, including registration and certification of the domestic partnership. Contact the TBT Plan Administration Office to confirm the specific enrollment requirements.*

Application Process for Domestic Partner Coverage

You must send the TBT Plan Administration Office a copy of your *California Declaration of Domestic Partnership* and *Certificate of Registration of Domestic Partnership* within 30 days after it is issued by the California Secretary of State (or the equivalent municipal authority as explained in the *Exception* on this page).

Your Domestic Partner's Eligibility Date

Eligibility for your qualified domestic partner follows the same rules as for a legal spouse (explained under *When Coverage Begins for Your Spouse* on pages 5-6). Keep in mind that coverage cannot begin until the first day of the month immediately following the date when the required forms and documentation are received and approved by the TBT Plan Administration Office by the deadlines explained under *When Coverage Begins for Your Spouse* on pages 5-6.

Self-Payments are Required

To participate in the Plan, monthly self-payments (payable to the Teamsters Benefit Trust) are required for you and your covered spouse. Since there can be no gap in coverage, self-payments must begin the first month after your coverage as an active employee ends (unless you first choose COBRA continuation coverage explained on pages 10-11).

All self-payments are due on the first day of each month. If self-payments are not received by the TBT Plan Administration Office by the last day of the month, coverage for you and your covered spouse permanently ends (effective on the first day of the same month). No benefits will be paid for any month when self-payments are not received. See pages 9-10 for information about *When Coverage Ends*.

Self-Payment Contribution Rates

Self-payment rates are established by the TBT Board of Trustees. They are evaluated by the Board of Trustees on a regular basis and are subject to change whenever necessary.

Self-payment rates depend on whether you and your eligible spouse (if married) choose coverage under the Indemnity Medical option or a Health Maintenance Organization (HMO) available in your area. See pages 7-8 for information about choosing an HMO. Rates also depend on whether you and/or your covered spouse are Medicare-entitled participants. Current medical plan options and self-payment rates will be provided separately by the TBT Plan Administration Office.

Monthly Statements

The current amounts that you are required to pay for your coverage are reflected in your monthly statement. Monthly self-payment rates apply to each covered person (retiree and eligible spouse).

Rates for those who are not yet Medicare-entitled are based on age. Each month, your statement reflects the amounts you must pay based on each covered person's age in the month when the self-payments are due.

Employer Contributions May Apply

Your former Employer may be required to make contributions for retiree coverage. Such contributions may be in the form of:

- an obligation under a Union contract to make contributionson behalf of active employees that result in a subsidy or reduction of retiree self-payment rates (in an amount determined by the Plan). In this case, subsidies and the TBT-approved rate reduction apply to the retiree's self-payment only. The spouse's self-payment rate is not subject to reduction by Employer subsidy, or
- an agreement (contractual or otherwise) to make partial or full contributions to the Plan on behalf of its retirees and in some cases, their spouses. Check with your former Employer or refer to your collective bargaining agreement for details.

If you are eligible for any type of Employer contributions, your monthly statement reflects the reduction in your self-payment amount. You are required to pay the full amount if your former Employer stops contributing or is no longer contractually obligated to contribute for retiree coverage.

When Your Coverage Begins

Your retiree coverage begins on the first day of the month following your last month of eligibility under your active TBT Plan (or other plan approved for participation by TBT) as long as all the enrollment requirements are met and the appropriate forms and self-payments are received by the TBT Plan Administration Office within 30 days of your planned retirement date. Retiree coverage may begin at a later date, but no later than 12 months after coverage as an active employee ends, unless you qualify for delayed enrollment (see *Retiree Eligibility Rules* number 6 and Exceptions on page 2).

Note: If you are a disabled retiree, your coverage begins on the *Certificate Issued* date on your Pension Plan certificate or similar notice, as long as the appropriate enrollment forms are received in a timely manner. See the *Disability Exception* on page 2.

When Coverage Begins for Your Spouse

Coverage begins for your *eligible spouse* when your coverage begins—as long as all the enrollment requirements are met and the appropriate forms and self-payments are received by the TBT Plan Administration Office by the enrollment deadlines explained in *How to Enroll* on page 6. *If you do not enroll your spouse for coverage when he or she first becomes eligible (except as noted on page 3, number 2), coverage for your spouse cannot be added at a future date.*

ENROLLING A NEW SPOUSE

*You must enroll a **new** spouse in the Plan no later than 60 days after the date of the marriage. (See Spouse's **Eligibility** number 3 on page 3.)*

HMOs have specific requirements for adding or removing a spouse. *If you are enrolled in an HMO, see the HMO enrollment material for information about enrolling or stopping coverage for a legal spouse.*

Remember, all changes are made through the TBT Plan Administration Office, even if you choose HMO coverage. (See *Change in Marriage Status* on page 9.)

How Coverage Continues

Once coverage begins, you and your covered spouse continue to be eligible for benefits under the Plan as long as all required self-payments are received by the TBT Plan Administration Office on time and in full. Your eligibility for benefits in any month depends on all required self-payments being received in a timely manner (see *When Coverage Ends* on pages 9-10).

If you do not make timely self-payments, coverage ends for you and your covered spouse as of the first day of the month following the month for which the last timely self-payment was made.

Continued eligibility may also depend on your former Employer's ongoing participation (see *When Coverage Ends* on pages 9-10).

Your self-payments provide coverage for the month when they are due. No benefits will be paid for any month for which self-payments are not received by the TBT Plan Administration Office.

After you enroll, you may drop your coverage at any time for any reason. *However, if you drop your coverage, you may not re-enroll at any time in the future. If you drop coverage for yourself, your spouse will also lose coverage.*

If you divorce after retirement, coverage for your covered spouse ends on the first day of the month following your divorce (even if you have not yet notified the TBT Plan Administration Office by the 60-day deadline). See *Change in Marriage Status* and *When Coverage Ends* on pages 9-10. **Note:** *Your former spouse may be eligible to elect COBRA coverage following the procedures and deadlines explained on pages 10-11.*

How to Enroll

Application. You must apply for Plan coverage by sending the TBT Plan Administration Office a completed *Application for Retiree Benefits* within 30 days of the date you want retiree coverage to begin. So that you may meet this deadline, you should request an application from the TBT Plan Administration Office a few months before your scheduled retirement.

Future changes in your medical option can be made once every 12 months. (See *Open Enrollment—Changing Your Medical Option* on page 8).

Once your application request is received, the TBT Plan Administration Office verifies that you meet the eligibility requirements (explained on page 2) and mails you a benefits package that includes a *TBT Retiree Enrollment Form*. You also receive a *Summary of Coverage* and *Comparison of Medical Benefits* that explain the benefits offered by each medical option and a list of current self-payment rates.

Enrollment. You enroll yourself and your eligible spouse by sending in your self-payments and returning all of the following forms (provided by the TBT Plan Administration Office):

1. **TBT Retiree Enrollment Form.** The process of starting your CRP benefits won't begin until this form is received (see *Why Enroll?* to the right).
2. **Retiree Medical Option Form.** Use this form to choose your medical option (which must be the same for you and your covered spouse).
3. **HMO Application.** If you choose coverage under an HMO, an HMO application is also needed (see *How to Apply for HMO Coverage* on page 7). Some HMOs may send you this information before you retire from active employment (while you are still covered under a TBT Plan). If you need an HMO packet and application, contact the TBT Plan Administration Office.

MEDICARE COVERAGE

Medicare Parts A and B Enrollment

If either you or your covered spouse is age 65 or older (or otherwise eligible for Medicare), but not enrolled, contact your local Social Security Administration Office for details about Medicare and Medicare enrollment procedures. It is best to inquire about three months prior to your 65th birthday (or, if disabled, as soon as you are eligible). ***If you are age 65 and eligible for Medicare, but have not enrolled in Medicare Parts A and B, your benefits will be paid as if you are Medicare-entitled even if you have not elected to enroll in Medicare Parts A and B.***

If you are eligible for Medicare, the Comprehensive Retiree Plan integrates benefits with Medicare and pays benefits as if you are fully Medicare-entitled, even if you are not. Therefore, to receive maximum benefits, you must be enrolled in both Medicare Parts A and B. *See* ***About This Plan and Medicare*** *on page 13.*

Prescription Drugs—Outpatient

CRP participants covered under an HMO Medicare Plan, receive prescription drugs through the HMO. All other participants (Indemnity Medical and HMO non-Medicare options for Early Retirees) have prescription drug coverage through Prescription Solutions.

See the CRP *Comparison of Medical Benefits* and the separate HMO material including the *Evidence of Coverage and Disclosure* form.

Why Enroll?

There are important reasons why you should not delay sending in your *TBT Retiree Enrollment Form*, *Retiree Medical Option Form*, HMO application (if you choose an HMO), and if applicable, proof of entitlement.

- Coverage is not automatic. You risk forever losing the opportunity to enroll.
- No claims are paid until all the required forms and self-payments are received and you are enrolled.
- If you want medical coverage through an HMO option , you cannot be enrolled without the required forms mentioned above *plus* an HMO application.
- Your prescription drug card will not be ordered for you until a *TBT Retiree Enrollment Form* is received.

IMPORTANT

Your prescription drug card is mailed to you as close to your eligibility date as possible. If you are eligible for prescription drug benefits, but have not yet received your prescription drug card, you may be reimbursed for covered benefits (see ***When Your Coverage Begins*** *on page 5).*

- You won't receive important notices about your benefits if the Plan does not have your mailing address.
- You and your covered spouse may face delays when you need to use your benefits.
- Health care providers cannot verify your coverage.
- If you and/or your covered spouse are eligible for Medicare, but not enrolled in Medicare Parts A and B, substantial limits apply to benefits (see *About This Plan and Medicare* on page 13).

ENROLL EARLY!

Your ***TBT Retiree Enrollment Form*** *and all other required forms (including HMO applications) must be received by the TBT Plan Administration Office within 30 days of your retirement from active employment (see* ***How to Enroll*** *on page 6).*

Contact the TBT Plan Administration Office if you need an ***Application for Retiree Benefits****, a* ***TBT Retiree Enrollment Form*** *or any other missing or extra forms that you may need. (Do NOT send any enrollment materials directly to an HMO or your enrollment may be delayed.)*

Indemnity Medical Option or Health Maintenance Organization (HMO) Option

TBT offers a choice of medical coverage. You may choose the Indemnity Medical option explained on pages 12-22 of this guide or coverage under a Health Maintenance Organization (HMO) offered through TBT.

The Indemnity Medical option is available no matter where you live. To choose an HMO option available through TBT, you and your covered spouse *must live within the HMO service area where coverage is available.* The *Comparison of Medical Benefits* lists the service areas for each HMO by county. Check with each HMO for the most current details about their service areas and facilities. The phone numbers and web sites are listed on the back cover.

How to Apply for HMO Coverage

If you want new or continued coverage under an HMO option when you are newly eligible, send your:

- *Application for Retiree Benefits*,
- *Social Security or pension entitlement documentation*,
- *TBT Retiree Enrollment Form*,
- *Retiree Plan Election Form*,
- *Retiree Medical Option Form*,
- *HMO Application, and*
- *Copy of Medicare ID card (if applicable)*

…*directly* to the TBT Plan Administration Office for processing. Check your *Summary of Coverage* and HMO *Evidence of Coverage* for the most current information about your HMO option. The HMO *Evidence of Coverage* is contained in the HMO enrollment packet already provided to you or can be obtained by calling the TBT Plan Administration Office.

Note—Medicare Enrollment and HMOs: *HMOs require that you enroll in Medicare Parts A and B if you are eligible and continue your enrollment as long as you are an HMO member. If you do not enroll, the HMO may apply a surcharge to the rate it charges TBT which you may be required to pay. It may also apply special limits to your benefits or cancel your membership.*

IMPORTANT
*All enrollment forms (including the **required HMO application**) must be sent to the TBT Plan Administration Office. Do NOT send any enrollment materials directly to the HMO or your enrollment may be delayed.*

Other TBT Benefits for HMO Participants

HMO participation only applies to medical coverage. Other TBT benefits are not affected by the TBT medical option you choose.

Prescription drug benefits for all participants are provided by TBT, even if you enroll in an HMO. (See *Prescription Drug Benefits* beginning on page 26.)

Exception: If you are enrolled in a "*Medicare HMO Plan*" (see definition on page 50), prescription drug benefits are provided by that HMO rather than by TBT.

HMO participants may be eligible for certain *alcohol or chemical dependency* treatment under the Indemnity Medical option (see page 21 of this guide and your *Comparison of Medical Benefits*). However, emergency treatment in an acute care hospital related to *alcohol or chemical dependency* is *not* covered under the Indemnity Medical option for HMO participants. Any emergency treatment would only be covered as provided by the HMO (see the separate disclosure materials from the HMO for details).

Not All Coverage is the Same

There are important differences between coverage under the TBT Indemnity Medical option and HMOs.

- The main difference is that HMOs limit you to use HMO providers. If you choose HMO coverage and go to a *hospital, doctor or health care provider* that is not in the HMO, your claims are not covered by the HMO (unless the claim involves an *emergency* as defined by the HMO).
- If you choose an HMO, medical benefits are payable through the HMO (not the Indemnity Medical option) except as specifically noted in this guide and your *Summary of Coverage*. Packages explaining HMO coverage, service areas, claims procedures, enrollment applications and forms are available through the TBT Plan Administration Office.
- HMO participants must contact the HMO directly about benefits questions and claims appeals. Telephone numbers for the HMOs currently offered by TBT are listed on the back cover. Note that the HMOs offered may change.

Open Enrollment—Changing Your Medical Option

After you choose your initial TBT medical option, you may change your medical option once every 12 months. Each time you change your medical option, a new 12-month period begins. *You and your eligible spouse must be covered under the same medical option.*

Note: You will not be sent a medical option change form unless you request one. There are no annual mailings.

When you want to make a change:

1. Contact the TBT Plan Administration Office to confirm your eligibility to change your option.
2. Submit the *Medical Option Information Order Form* indicating the medical or HMO material you would like to review. This order form may be found in the enclosed *Forms* folder. If you need a copy of this form, you may ask for one from the TBT Plan Administration Office.
3. You will receive a packet with the material you requested and the required enrollment change forms. Once you review the material, fill out and submit the *Medical Option Change Form* to the TBT Plan Administration Office. **Note:** If changing to an HMO, an HMO application is also required and will be sent to you with the HMO material you requested.

Effective Date of Open Enrollment Changes: Open Enrollment change requests submitted on the required medical change form will be effective the first day of the **second** month following receipt of the change request. For example, if your change form is received on September 17, the change will be effective November 1. *This assumes that all the required forms have been submitted and you are eligible for benefits.* **So if you are changing your medical option, do not assume that you are enrolled in your new coverage until you receive confirmation from the TBT Plan Administration Office.** *You may also contact the TBT Plan Administration Office to confirm that your new coverage is in effect.*

Questions: All Open Enrollment change requests must be submitted **in writing** to the TBT Plan Administration Office using the required medical option change form. **However, you may phone the TBT Plan Administration Office to:**

- Request information on the available medical options.
- Request HMO (medical) benefit and enrollment material.
- Request medical change forms.
- Consult with a customer service representative regarding your specific circumstances, or
- Confirm the effective date of new coverage (as noted).

When you call, please ask for the Open Enrollment Unit.

If you do **NOT** request changes, your current medical options will remain in effect as long as they are offered by TBT. From time to time, TBT may change the available options. If this occurs, you will be notified and may then choose any of the currently available options.

You may also be able to change your medical option when you move out of an HMO service area. If you become Medicare-entitled, you may change to a Medicare HMO Plan at any time.

Important Note: You and your eligible spouse must be covered under the same medical option.

IMPORTANT

For HMO coverage to be effective, all forms (including the required HMO application) and self-payments (if any) must be received by the TBT Plan Administration Office (as explained on page 7).

Change in Marriage Status

It is your responsibility to notify the TBT Plan Administration Office in writing by the deadlines below when a change occurs that affects your spouse's eligibility.

You *must* **notify** the TBT Plan Administration Office **within 60 days** if:

1. You get married.
2. You establish a domestic partnership.
3. Your spouse dies.
4. You divorce or dissolve your domestic partnership. See *When Coverage Ends* on this page.

With your notice, send a copy of your:

- Marriage certificate
- Certification of domestic partnership
- Death certificate
- Divorce decree or domestic partner dissolution certification

…to the TBT Plan Administration Office.

If you have HMO coverage, the TBT Plan Administration Office will send you a *Change of Status Form* (required by the HMO) upon request.

DIVORCE NOTICE WITHIN 60 DAYS

You should notify the TBT Plan Administration Office as soon as possible if you divorce. If you wait until after the divorce and the Plan pays benefits for your former spouse, ***you*** *could be responsible for paying back the overpayment to TBT,* ***even if you notify TBT within the 60-day window explained on this page****. It is therefore in your interest to submit a copy of your divorce decree to the TBT Plan Administration Office within 60 days of the divorce date. See* ***Right of Reimbursement*** *on page 35.*

When Coverage Ends

Coverage for you and/or your covered spouse ends on:

1. The date when you or your spouse are no longer eligible for Plan benefits.
2. For specific benefits, the date when the covered maximum is reached for that covered participant or when the benefit is discontinued.
3. The first day of a month for which the required self-payments are not received by the last day of the same month.
4. The date when the Plan ends.
5. The first day of the month following the month in which the Employer from which you retired bargains out of TBT and into another group health plan and stops contributing to TBT on behalf of active employees. However, if your former Employer leaves the area or stops operations altogether, you may continue your eligibility in the Plan by self-payment. Contact the TBT Plan Administration Office for details.

Coverage for your covered spouse ends at the same time yours ends, or sooner:

1. If you divorce, on the first day of the month after your divorce is final.
2. On the first day of the month for which the required self-payment is not received by the last day of the same month.

HEALTH INSURANCE PORTABILITY

When coverage ends, federal law requires that the Plan provide a ***Certificate of Group Health Plan Coverage*** *to you. This certificate is intended for use by any new plan in which you enroll.*

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires certain group health plans to offer the spouse of a retired employee (if the spouse is covered by the Plan) the option to continue coverage by self-payment after eligibility in the CRP has ended due to divorce (a *qualifying event* described on this page).

Notifying the Plan of a Qualifying Event

If you divorce, your spouse may elect COBRA coverage by self-payment in the Comprehensive Retiree Plan (CRP) for up to 36 months. **A divorce must be reported to the TBT Plan Administration Office within 60 days.** See *Change in Marriage Status* on page 9.

Notice may be provided by anyone acting on your spouse's behalf. Failure to provide notice within this 60-day time period will result in the loss of your spouse's right to elect COBRA coverage. The notice must be sent to:

TBT Plan Administration Office
Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

The notice must contain (at a minimum):

- The name of the retiree,
- The name of the spouse who seeks COBRA coverage,
- The date and a description of the qualifying event (divorce), and
- A copy of the divorce decree.

Additional information may be requested if necessary. Contact the TBT Plan Administration Office for details.

If you are covered by a regional plan (like an HMO that covers a limited geographic area) and you move to another area where your former Employer has an active workforce, you may be eligible to enroll in the benefit plan available to active employees in that area. However, such a transfer will not prolong your 36 months of COBRA coverage.

COBRA Election

After learning of your spouse's qualifying event, the TBT Plan Administration Office will send a letter to you and your spouse explaining your spouse's COBRA coverage option. *This letter will be sent to the address of record maintained by the TBT Plan Administration Office. You and your spouse are responsible for keeping your mailing address up to date.*

A COBRA election form (called *Notice of Qualifying Event*) is in your *Forms* folder. If you need a form, contact the TBT Plan Administration Office.

The 60-day COBRA election period begins on the *later* of the following dates:

1. The date coverage under the Plan would otherwise end because of the qualifying event, or.
2. The date your spouse is sent notice of his or her right to elect COBRA coverage.

COBRA Payments

Self-payments are required of the spouse for COBRA coverage after the qualifying event (divorce). Your spouse's first COBRA payment may be sent in with the COBRA election form or sent in separately. If sent after the election form, your spouse's first COBRA payment must be received by the TBT Plan Administration Office within 45 days of the date your spouse elects COBRA coverage. Your eligible spouse electing COBRA must pay the full monthly self-payment for the coverage elected. There may be no gap in coverage. *Payments must be retroactive to the date when coverage ends.*

Under COBRA, your spouse will pay the full cost of coverage plus a 2% administration fee—in other words, 102% of the cost of continuing coverage. The COBRA premium rate is determined annually by the Board of Trustees.

After the initial COBRA payment, subsequent payments are due on the first of the month and are delinquent if not received by the 30th day of the month. Your spouse will not be billed and is responsible for getting payments in on time.

If your spouse elects COBRA, the COBRA option your spouse has chosen and the monthly premium will cover only your eligible spouse.

If your spouse sends a timely monthly contribution that is significantly less than the actual payment due, COBRA coverage is terminated immediately. If your covered spouse sends a payment that is not significantly less than the actual COBRA payment due for the month, the TBT Plan Administration Office may notify your spouse of the shortfall and require that it be received within 30 days. A COBRA payment is not considered significantly less than the actual payment due if the shortfall is less than or equal to the lesser of $50 or 10% of the actual COBRA payment due.

When COBRA Coverage Ends

The COBRA period, which started when your spouse experienced the *qualifying event* (divorce) described in this section, ends on the *earliest* of:

1. The end of the 36-month period described in this section.
2. The first day of the month in which your spouse's payment is not received within 30 days of the due date.
3. The date when your spouse becomes covered under another group plan unless the new group plan contains any exclusions or limitations for pre-existing conditions that directly affect your spouse's coverage. At the end of any such exclusions or limitations, COBRA eligibility under TBT ends.
4. The date your spouse first becomes eligible for Medicare after electing COBRA coverage.
5. The date the Plan ends.
6. The date when your former Employer stops providing Plan benefits to any retiree.
7. The date determined by TBT that your spouse's coverage will end due to any fraud or misrepresentation or because you or your spouse knowingly provided TBT or the TBT Plan Administration Office with false information including, but not limited to, information relating to another person's eligibility for coverage or status as a spouse. The Trust reserves the right to cancel coverage back to the effective date of coverage.

Notice of Unavailability of COBRA

If, after receiving a notice relating to a qualifying event, TBT determines that there is no entitlement to COBRA coverage, the TBT Plan Administration Office will provide your spouse with a notice explaining the reasons why COBRA coverage is not available. The notice will be provided no later than 30 days after the Plan is notified.

Notice of Early Termination

If TBT terminates COBRA coverage prior to the end of your spouse's 36-month coverage period, the TBT Plan Administration Office will provide your spouse with a notice as soon as practicable following the determination to terminate COBRA coverage. The notice will explain the reason for the early termination and the effective date of the termination.

The Plan's COBRA provisions are meant to comply with applicable federal law. If changes in the law differ from the COBRA information provided here, the changes will govern.

If you have questions about COBRA eligibility or benefits, contact the TBT Plan Administration Office.

REMINDER

The TBT Plan Administration Office will mail your spouse's COBRA notice to the home address listed on your ***TBT Retiree Enrollment Form****. You must notify the TBT Plan Administration Office whenever you or your spouse change your address.*

If You Have Eligibility Questions

Call the TBT Plan Administration Office with your questions. Benefits under each TBT Plan are different. When calling, refer to your Plan as the Comprehensive Retiree Plan (CRP).

IMPORTANT

Only the TBT Plan Administration Office can verify eligibility. Statements or documents about eligibility or coverage provided by other sources, such as your former Employer or Union, will not be honored if in error.

YOUR TBT MEDICAL OPTIONS

You may choose one of the medical plan options shown on your *Retiree Medical Option Form*. The options include the Indemnity Medical option or a TBT-sponsored Health Maintenance Organization (HMO) if available where you live.

COMPARISON OF MEDICAL BENEFITS

See the *Comparison of Medical Benefits* to select your TBT medical plan option. It shows how the options compare and explains important features such as the Anthem Blue Cross PPO network. You can also consult your *Summary of Coverage* for details about your benefits under your TBT Plan.

The *Comparison of Medical Benefits* is a summary only. It does not fully describe your TBT medical benefits.

If you have coverage through an HMO offered by TBT, these benefits are explained in separate material from the HMOs. For details on the HMOs offered by TBT, refer to your *Summary of Coverage* or each HMO's *Evidence of Coverage*.

EVIDENCE OF COVERAGE

The *Evidence of Coverage* is the binding document between the HMO and its members. The HMO's *Evidence of Coverage* is sent to you at no charge when you enroll or can be obtained by calling the TBT Plan Administration Office or the respective HMO.

The HMO's health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose or treat your medical condition. The services and supplies must be provided, prescribed, authorized or directed by a health plan physician.

For example, if you are enrolled in Kaiser, the services and supplies must be provided, prescribed, authorized or directed by a Kaiser health plan physician. You must receive the services and supplies at a Kaiser health plan facility or skilled nursing facility within Kaiser's service area, except where specifically noted to the contrary in Kaiser's *Evidence of Coverage*.

If you are enrolled in another Health Maintenance Organization offered by TBT, the medical services and supplies must be provided, prescribed, authorized or directed by the HMO's network provider. You must receive the services and supplies through the HMO's network physician or provider within the HMO's geographic service area, except where specifically noted to the contrary in your HMO's *Evidence of Coverage*.

For details on a TBT-sponsored HMO's benefit and claims review and decision procedures, refer to the HMO's *Evidence of Coverage*. To obtain a copy of the HMO's network directory, call the TBT Plan Administration Office or the respective HMO.

YOUR MEDICAL BENEFITS

This section explains your medical benefits through the Indemnity Medical option. You'll also need to check your *Comparison of Medical Benefits* and *Summary of Coverage* for specific information about your TBT Plan, such as the calendar year deductible, copayment percentages, special benefits and maximum amounts.

If you have coverage through an HMO offered by TBT, these benefits are explained in separate material provided by the HMO. See page 13 for more information about the HMOs. Contact the TBT Plan Administration Office to request HMO enrollment packets.

You may also receive *Plan Change Notices* or a *Summary of Material Modifications* explaining important changes to your coverage. Keep these notices in this package so you can refer to the most current information about your benefits.

REMINDER

To enroll in an HMO offered through the Teamsters Benefit Trust, you must live in the HMO service area. Detailed information about an HMO option available through TBT may be found in the separate material from these organizations. For information about an HMO option in your area, call the TBT Plan Administration Office.

*You can also check the **Comparison of Medical Benefits** for highlights of the Indemnity Medical and HMO options. However, refer to the separate material from the HMO for the most current information.*

IMPORTANT

*The medical benefits summarized here and in the enclosed **Summary of Coverage** are provided through the Indemnity Medical option. Read this guide to learn how the Indemnity Medical option works so you can get the highest possible benefits. If you choose to enroll in an HMO option, your medical benefits are determined and paid by the HMO (not by TBT).*

ABOUT THIS PLAN AND MEDICARE

If either you or your covered spouse is age 65 or older (or otherwise eligible for Medicare), the Plan integrates benefits with Medicare and pays benefits as if you are fully Medicare-entitled, even if you are not enrolled. Contact your local Social Security Administration Office immediately to ensure that you are enrolled under Medicare Parts A and B.

Medicare Part A is usually free of charge and generally provides hospital coverage at 100% of the Medicare-approved amount (after deductibles). Enrollment is automatic when you apply for Social Security benefits.

Medicare Part B is supplemental medical insurance which generally pays 80% of the Medicare-approved amount for outpatient hospital and doctors' services. You must apply for Part B benefits and pay a monthly premium. For full protection, you must be enrolled in both Parts A and B.

Contact your local Social Security office for information about Medicare-covered benefits at 1-800-MEDICARE or visit their web site at **www.medicare.gov**.

IMPORTANT

*Plan benefits for any covered person who is eligible for Medicare but not enrolled are paid under **Medical Benefits For Medicare Participants** beginning on page 22, not under the following section (entitled **Medical Benefits For Non-Medicare Participants**) beginning on page 15. If you or your covered spouse is Medicare-entitled, skip to page 22.*

Medicare Status

The information on this page explains how CRP benefits are provided depending on your Medicare Status.

If You are Medicare-entitled (Usually Age 65 or Older)

1. If you are entitled to Medicare Parts A and B, Medicare usually pays first (as the primary carrier) and the Plan pays second (as the secondary carrier). The Plan integrates benefits with Medicare and does not cover charges higher than Medicare-approved amounts.

2. The Plan pays Medicare deductibles and copayments (at the percentages listed in your most recent *Summary of Coverage*) after you have satisfied the Plan deductible.

Note: *If you are Medicare-entitled, additional limits apply even if you are not enrolled (see page 13). The Plan integrates benefits with Medicare as if you are enrolled in both Parts A and B. If you are Medicare-entitled, the Plan pays a maximum benefit of 20% on any expenses that would otherwise be covered by Medicare.*

3. Hospital Pre-admission Certification, Utilization Review, Case Management, Preferred Provider Organization (PPO hospital, physician or other provider) and Teamsters Assistance Program (TAP) requirements do not apply to Medicare-entitled participants.

4. Medicare-participating Providers: Only some doctors and medical care providers agree to accept Medicare-allowed amounts as *payment in full* for all services provided. These providers are Medicare-participating providers. Other providers may accept assignment of Medicare payments on a case-by-case basis or not at all. For information about Medicare-participating providers, contact your local Social Security Administration Office.

If you are entitled to Medicare, it is to your advantage to seek services from a doctor, hospital or other provider who is eligible to receive reimbursement from Medicare, because the Plan will only pay 20% of the Medicare-approved amount of any claim even if the provider may not or does not accept payment from Medicare. The Plan expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare, including payment under Medicare Parts A or B, a Medicare HMO or a Medicare + Choice plan.

See *Claiming Benefits* (beginning on page 30) for details about claim filing and appeals procedures.

If You are Not Medicare-entitled (Usually Under Age 65)

1. Pre-admission Certification and Utilization Review procedures are required for all non-emergency hospital stays and within 72 hours of an emergency hospital admission for participants who are not yet Medicare-entitled. Failure to obtain Pre-admission Certification through Blue Cross Life and Health (the Plan's Review Organization) results in a 20% reduction of benefits otherwise payable.

2. Teamsters Assistance Program (TAP) is the Plan's review organization to oversee and pre-approve all alcohol or chemical dependency treatment for participants who are not yet Medicare-entitled. If you or your covered spouse require this type of treatment, call (800) 253-TEAM or (510) 562-3600 in advance of treatment.

3. A Preferred Provider Organization (PPO) is a hospital, physician or other provider belonging to the Anthem Blue Cross Prudent Buyer PPO Network in California or to the Blue Cross Blue Shield Nationwide PPO Network outside of California (the Plan's Preferred Provider Organizations). A non-PPO is a provider who does not belong to the Anthem Blue Cross or Blue Cross Blue Shield Nationwide PPO networks. Your *Summary of Coverage* shows how you save out-of-pocket costs by using PPO providers.

It is to your advantage to use PPO providers whenever possible. In general, you receive higher benefits and have lower out-of-pocket costs if you use PPO rather than non-PPO providers. Non-PPO expenses are based on Usual, Customary and Reasonable (UCR) charges, which are usually higher than the PPO contract rates (resulting in higher out-of-pocket expenses).

It's your responsibility to make sure that you are using PPO providers if you are not yet Medicare-entitled and you want to reduce your out-of-pocket costs. To locate the nearest PPO hospitals, doctors, medical labs and clinics, check the Blue Cross PPO network provider directory available through the TBT Plan Administration Office. Since the participating providers are subject to change, California residents can check that a hospital or doctor is a PPO provider by calling Blue Cross toll-free at (888) 887-3725. Non-California residents can verify that their provider is in the PPO by calling (800) 810-2583.

See *Claiming Benefits* (beginning on page 30) for details about claim filing and appeals procedures.

MEDICAL BENEFITS FOR NON-MEDICARE PARTICIPANTS

This section explains medical benefits through the Indemnity Medical option for participants who are not eligible or entitled to Medicare. Once you are age 65 or otherwise entitled to Medicare, Medicare is the primary source of your benefits; your Plan coverage is secondary. Medical benefits for Medicare participants are explained on pages 22-23.

You'll also need to check your *Summary of Coverage* for specific information about this Plan, such as the calendar year deductible, copayment percentages, special benefits and maximum amounts. If you have coverage through an HMO offered by TBT, these benefits are explained in separate material from the HMO. See pages 7-8 for more information about HMOs. Contact the TBT Plan Administration Office or the HMO to request an HMO enrollment packet.

You may also receive *Plan Change Notices* or a *Summary of Material Modifications* explaining important changes to your coverage. Keep these notices in this package so you can refer to the most current information about your benefits.

PPO NETWORK

If you choose the Indemnity Medical option and are not yet Medicare-entitled, the amount paid on your claims will be higher when you take advantage of the Anthem Blue Cross Prudent Buyer network of preferred providers (called a PPO). PPO hospitals, doctors, clinics and medical labs agree by contract to accept reduced rates and fee ceilings (which means important savings to TBT and to you).

When you use non-PPO providers, claims are paid based on a percentage of Usual, Customary and Reasonable (UCR) rates—which usually means that you will pay more out-of-pocket when you do not use PPO providers.

It's your responsibility to make sure that you are using PPO providers if you want benefits to be paid at the PPO rates.

To locate the nearest PPO hospitals, surgery centers, doctors, medical labs and clinics, check the Anthem Blue Cross Prudent Buyer network directory available through the TBT Plan Administration Office.

Since participating providers change often, always confirm that a doctor or hospital is a PPO provider before receiving services by calling Blue Cross at (888) 887-3725 or (800) 810-2583 outside of California.

WHAT IS COVERED—THE INDEMNITY MEDICAL OPTION

The Indemnity Medical option pays a percentage of either PPO contract rates or Usual, Customary and Reasonable (UCR) charges for medically necessary services and supplies authorized by a doctor for treatment of illness or injury.

PPO Versus Non-PPO

The Anthem Blue Cross Prudent Buyer PPO Network is the Indemnity Medical option's Preferred Provider Organization (PPO) for hospitals, doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health providers and other providers. Costs for covered services from PPO network providers are usually lower than charges for the same services by non-PPO providers.

See your PPO network directory for a list of current providers. Since participating providers change often, always confirm that a doctor or hospital is a PPO provider before receiving services. California residents can verify that their provider is in the PPO by calling (888) 887-3725 toll-free. Non-California residents can verify that their provider is in the PPO by calling (800) 810-2583 toll-free.

When you use a PPO hospital for inpatient care, the Plan generally pays 100% of PPO contract rates for covered expenses. For most *outpatient* services, the Plan pays 80% of covered expenses for PPO providers and 80% of UCR for non-PPO providers (see your *Summary of Coverage*).

Note: The PPO coverage rates only apply when services are from PPO providers who have agreed to accept lower contracted rates. See your *Summary of Coverage* for specific information.

Normally, PPO providers do not require advance payment from you at the time you receive services. The PPO provider bills the Plan first. After the Plan pays, you are billed for your portion (if any).

Billing for your portion (if any) takes place after the Plan has processed the claim and sent you and the health care provider an *Explanation of Benefits* (EOB). If you don't use a PPO provider within the PPO network, the Plan covers a lower percentage (usually 80%) of Usual, Customary and Reasonable (UCR) charges. See your Summary of Coverage for your Plan's PPO percentages.

If your non-PPO provider's charges are *higher* than the Plan's UCR limits, you pay any extra amounts.

Plan Deductibles

Deductibles are amounts you and your covered spouse pay each calendar year before medical benefits are payable by the Plan. The deductible amounts are listed in your *Summary of Coverage*.

You and your covered spouse have *separate* deductibles for covered medical expenses.

Your Share After the Deductible

In addition to the deductible, you and your covered spouse may be responsible for a portion of covered expenses. These amounts are called your *copayments*.

Your *Summary of Coverage* lists the percentage the Plan pays for non-Medicare participants (which may be 100%, 90%, 85%, 80%, 70% or 50%, depending on the specific type of covered expense). The balance is your copayment. For example, if the Plan pays 80% for certain charges, your copayment is 20%.

Remember that you are responsible for paying all non-covered charges and any charges above Usual, Customary and Reasonable (UCR) if you use a non-PPO provider. Charges above UCR would be in addition to your copayment and payable by you.

Exceptions Not Subject to Copayment

Some benefits are not subject to your deductible or copayments. Your *Summary of Coverage* lists the exact amounts for your TBT Plan.

How Benefits are Paid

-Preventive Care

PPO—90% of PPO Contract Rates or Non-PPO—90% of UCR charges

The Plan has a calendar year maximum for preventive care benefits (see your *Summary of Coverage*).

Charges for the following preventive care benefits are paid at 90%: Routine physical exams and related x-rays and lab work, flu shots, pap tests, routine mammograms and PSA tests for detection of prostate cancer.

It is to your advantage to use PPO providers, since the Plan pays 90% of PPO contract rates for covered expenses. If you do not use PPO providers, the Plan pays 90% of UCR charges (which are usually higher amounts resulting in higher out-of-pocket expenses).

-Physician Benefits

PPO—80% of PPO Contract Rates or Non-PPO—80% of UCR charges

Outpatient physician and surgery benefits include covered services of doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors and mental health providers.

If you use PPO providers, the Plan pays 80% of PPO contract rates for covered expenses. For non-PPO providers, the Plan pays 80% of Usual, Customary and Reasonable (UCR) charges. See your *Summary of Coverage* for deductibles and coverage limits.

IMPORTANT
*If your non-PPO provider's charges are **higher** than the Plan's UCR limits, you pay any extra amounts.*

Note: If you go to a PPO hospital's emergency room and are treated by a non-PPO physician, the Plan pays your physician's claim at the non-PPO rate (80% of UCR charges).

-Referral by PPO Providers

PPO—80% of PPO Contract Rates or Non-PPO—80% of UCR Charges

Non-PPO physician benefits are paid at 80% of Usual, Customary and Reasonable (UCR) charges even when referred by a PPO provider.

Your TBT Plan may have calendar year limits that also apply (see your *Summary of Coverage*).

-Hospital Benefits (Inpatient)

PPO—100% of PPO Contract Rates or Non-PPO—80% of UCR charges

Pre-admission Certification is required for all non-emergency hospital stays. Notice of emergency confinements must be approved as soon as possible following admission (and no later than 72 hours after admission). Failure to obtain Pre-admission Certification may result in a reduction of benefits.

The Plan has even stronger incentives to encourage you to use PPO hospitals for inpatient care. Benefits are reduced to 80% of UCR charges if you do not use a PPO *hospital when one is available within a 30-mile radius of your home*. These rates apply to inpatient hospitalization, including *miscellaneous hospital services* (defined on page 19).

-A Few Exceptions

There are three situations when *inpatient benefits* are not reduced if you use a non-PPO hospital:

1. If you are admitted as an inpatient during an emergency at a non-PPO hospital, the Plan pays as if you were in a PPO hospital until your condition is sufficiently stable for you to be safely transferred to a PPO hospital (as determined by Blue Cross Life and Health, the Plan's Utilization Review Organization). If Blue Cross Life and Health determines that you are sufficiently stable to be safely moved to a PPO hospital and you do not do so, the Plan pays at the 80% UCR non-PPO hospital percentage for the balance of any medically necessary hospital stay.
2. If there is no PPO hospital within a 30-mile radius of your home, the Plan pays at the higher PPO percentage.
3. If any PPO hospital within a 30-mile radius of your home cannot provide services or treatment for your illness or injury, the Plan pays at the higher PPO percentage.

These exceptions do not apply to inpatient care for *mental health services*. These Plan benefits are always reduced by 50% when services are provided by a non-PPO hospital (see *Mental Health Services* on page 20).

IF YOU NEED TO BE HOSPITALIZED

Prior authorization is required for all non-emergency hospital confinements. Notice of emergency hospitalization must also be approved as soon as possible following admission (72-hour maximum). Failure to obtain Pre-admission Certification results in a 20% reduction of benefits. Charges for non-certified hospital days are not covered under the Plan (see pages 18-19 for more information).

-Outpatient Services

(PPO—80% of PPO Contract Rates or Non-PPO - 80% of UCR charges)

Outpatient services are paid at 80% of PPO rates or 80% of UCR charges in a non-PPO hospital; however, outpatient surgery and treatment of *accidental bodily injury within 24 hours* are paid at 100% of PPO rates or UCR charges.

Note: *When referred by a PPO or non-PPO physician, outpatient laboratory and x-ray charges at PPO hospitals are paid at 80% of PPO contract rates for PPO providers or 80% of UCR for non-PPO providers.*

When referred to a PPO hospital for outpatient physical therapy, benefits are paid at 80% of the PPO contract rate.

What are Outpatient Services?

- Outpatient hospital services include services provided in an outpatient hospital setting (such as an emergency room or clinic), and
- Outpatient physician and surgery benefits include covered services of doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors and mental health providers.

WHAT IF NO PPO CHOICE?

Sometimes the patient has no choice over whether the services are from a PPO or non-PPO provider. However, the PPO rules remain the same (as explained in this section).

Most covered physician benefits are paid at 80% of Usual, Customary and Reasonable (UCR) charges if you do not use PPO providers. However, if you use PPO providers, the out-of-hospital benefits are paid at 80% of the lower PPO contract rates (which means you pay less).

For example, if you go to a PPO hospital's emergency room and are treated by a non-PPO physician, the Plan pays your physician's claim at 80% of UCR charges.

In the case of a referral by a PPO physician to a non-PPO hospital, benefits for outpatient lab and x-ray charges are paid at 80% of UCR. Your TBT Plan may have calendar year limits that also apply. See your ***Summary of Coverage*** *for details.*

Other PPO Incentives

Even though an expense is covered, it may not be paid in full. ***When you use PPO providers, your costs are lower. PPO doctors and hospitals charge reduced rates for their services, which helps keep costs down for you and the Plan.*** *Be sure to check with Anthem Blue Cross at (888) 887-3725 to confirm whether or not a hospital, doctor or other provider currently participates in the PPO network. (Non-California residents can verify that their provider is in the PPO network by calling (800) 810-2583 toll-free.)*

If you go to a non-PPO provider and your expenses are considered higher than the UCR amounts, you are responsible for paying any extra amounts (including any copayment amounts at the higher non-PPO percentage that you are obligated to pay).

Also, some charges may be limited or excluded under the Plan (unless you are Medicare-entitled). For example, if you fail to get Pre-admission Certification of any non-emergency hospital confinement, benefits may be reduced. Utilization Review is required for all hospitalizations and other case management procedures apply (see pages 18-19).

PPO Network for Non-California Residents

If you live outside California, the Indemnity Medical option participates in another network of preferred providers outside of California. For Pre-admission Certification, except for alcoholism or chemical dependency, phone Blue Cross Life and Health at (800) 274-7767. To locate the nearest PPO Hospital, you must call the Blue Cross Blue Shield Nationwide Network toll-free at (800) 810-2583.

Non-California residents are encouraged to use Preferred Provider hospitals for maximum savings for you and the Plan. Contact the TBT Plan Administration Office for more information.

Hospitalization in a non-preferred provider facility will result in a 20% loss of benefits. See your *Summary of Coverage* for details.

HOSPITAL REQUIREMENTS

(Not applicable if Medicare-entitled or eligible)

Pre-admission Certification

Pre-admission Certification is required before you are covered for any non-emergency hospitalization. Call Blue Cross Life and Health at (800) 274-7767 or make sure your doctor calls Blue Cross Life and Health before scheduling the hospital stay. *Failure to obtain Pre-admission Certification results in a 20% reduction of benefits. Charges for non-certified hospital days are not covered under the Plan (unless Medicare-entitled).*

In an emergency, Blue Cross Life and Health must be notified as soon as possible following *admission (and no later than 72 hours after admission).* The doctor's office must call Blue Cross Life and Health at (800) 274-7767. Once notified, the registered nurse coordinators and doctors at Blue Cross Life and Health conduct the certification and communicate their decisions to the doctor's office, often during the same phone call.

For hospitalization for *alcohol or chemical dependency*, different Pre-admission Certification procedures are required before an in-hospital stay. The Teamsters Assistance Program (TAP) must pre-certify and oversee hospitalization due to *alcohol or chemical dependency* treatment.

Phone TAP at (800) 253-TEAM or (510) 562-3600 for Pre-admission Certification.

The best time for you to notify Blue Cross Life and Health (or TAP if applicable) is when your doctor schedules an in-hospital stay. You, your doctor and the hospital will receive a written follow-up notice from Blue Cross Life and Health by mail. If you have not received a notice, you should verify that Pre-admission Certification has been conducted before going to the hospital. It's a good idea to check with Blue Cross Life and Health (or TAP if applicable) in advance. Remember, if Blue Cross Life and Health (the Plan's Utilization Review Organization) determines that hospitalization is not necessary—or that hospital services are not medically necessary—you, your doctor and the hospital are informed by Blue Cross Life and Health. Your doctor is contacted to confirm the need for hospitalization. Blue Cross Life and Health writes to tell you whether your hospital stay has been certified and, if so, for how long. *The Plan does not cover charges for non-certified days in the hospital.*

Blue Cross Life and Health certifies the medical necessity of a hospital stay; however, certification does not guarantee eligibility or benefits. You must be eligible at the time of the hospital stay and the medical procedures must be covered by the Plan.

There are also important deadlines related to claim filing procedures in the *Claiming Benefits* section beginning on page 30.

Utilization Review

Utilization Review is also required during all hospitalizations to monitor required services and related charges—even if the admission was due to an emergency. Blue Cross Life and Health is the Plan's current Utilization Review Organization.

Utilization Review ensures that the hospital stay is medically necessary and appropriate in length. If your doctor concludes that the inpatient stay needs to be longer than certified, your doctor must notify Blue Cross Life and Health in advance. If Blue Cross Life and Health determines that any in-hospital days are not medically necessary, these days are not covered.

The Utilization Review procedures are usually triggered by admission to a hospital. However, you must notify both the doctor and the hospital (either before or upon admission) that Utilization Review is required by the Plan. If the hospital treatment is for *alcohol or chemical dependency*, the Utilization Review procedures are conducted by TAP (see *Alcohol or Chemical Dependency Treatment Benefits* on page 21).

Case Management

Blue Cross Life and Health (the Plan's Utilization Review Organization) also reviews outpatient services in light of the patient's diagnosis and health care needs.

In some cases, a patient's needs may be met as well or better through an alternative to an acute care hospital confinement. Such treatment could include home, hospice or convalescent nursing home care.

In appropriate cases, Blue Cross Life and Health works with your physician to assess whether alternative care is suitable for the patient, to assure coordination of health care services and that these services are carried out in a way that ensures continuity and quality of care. The Plan covers alternative care only when it has been pre-approved by Blue Cross Life and Health.

COVERED EXPENSES

Hospital Benefits

Inpatient hospital benefits provided by a PPO hospital are paid at 100% of contract rates (with no deductible) up to the limits and maximum period (if any) explained in your *Summary of Coverage*. Check with Anthem Blue Cross at (888) 887-3725 to make sure you are using PPO providers to get maximum benefits. If you reside outside of California, contact the Blue Cross Blue Shield Nationwide Network at (800) 810-2583.

If either you or your covered spouse is admitted to a hospital for a covered illness or injury, the Plan pays room and board charges up to the hospital's standard charge for its semi-private room. Coverage is provided up to the maximum number of days (if any) stated in your *Summary of Coverage*.

But remember, you must obtain Pre-admission Certification of any non-emergency hospital admission by calling Blue Cross Life and Health in advance—*or TAP if treatment is for alcohol or chemical dependency—as explained on page 21*.

Covered Hospital Charges

1. Room and board up to the hospital's standard charge for a semi-private room.
2. Care in an intensive care, burn unit, coronary or other special care unit.
3. General nursing care and other services and supplies necessary for the care and treatment of the covered patient.
4. Room and board for the first 60 days of covered hospitalization in a *Skilled Nursing or Convalescent Care Facility* (see page 20 for additional restrictions).

Miscellaneous Hospital Services (Inpatient)

The Plan pays:

- Up to 100% of PPO contract rates (or 80% of UCR charges for non-PPO providers) for medically necessary inpatient supplies and services, up to the limits and the maximum period (if any) stated in your *Summary of Coverage*.

The following *outpatient* hospital services are covered at 100%:

- A surgical procedure performed on an outpatient basis to treat an injury or illness.
- Outpatient treatment for accidental bodily injury received within 24 hours of the accident.

Postpartum Hospitalization

Federal law prohibits restriction on benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery or less than 96 hours following a caesarean section. The Plan complies with this law and does not require prior authorization for hospitalization up to the time periods stated above. *However, the Plan does not provide coverage of any kind for a newborn or dependent child.*

Surgery and Doctors' Visits

1. Medically necessary professional services.
2. Services of one or more assistant surgeons, but not to exceed 20% of the maximum covered expenses for the services of the primary surgeon.
3. Outpatient psychotherapy and psychometric testing up to the Plan's maximum limits (see *Mental Health Services* on page 20).

Other Covered Expenses

1. Diagnostic treatment, x-ray and laboratory services.
2. Anesthetics and oxygen, including administration.
3. Registered or licensed vocational nursing.
4. Charges made by a licensed home health care agency for treatment administered within 90 days after five consecutive days of a covered hospital or convalescent hospital stay (additional home health care benefits may be covered if pre-certified by Blue Cross Life and Health).
5. Physical therapy performed by a licensed physical therapist.
6. Ambulance service (including air ambulance in those circumstances where passage by air appears to be medically necessary and not solely for convenience and the claim is reviewed and approved for payment by the TBT Plan Administration Office).
7. Rental (or purchase, when determined appropriate by the Plan's Utilization Review Organization) of braces and durable medical equipment for therapeutic treatment.
8. Initial artificial limbs, eyes or other prosthesis required to replace natural limbs, eyes or other parts of the anatomy lost while covered.
9. Initial foot orthotics.
10. Contraceptive implants and devices.
11. Hospice care.
12. Other treatments (including acupuncture) only when specific written TBT approval is provided in advance by the TBT Plan Administration Office.
13. Initial wig for temporary or permanent hair loss caused specifically by illness or injury, limited to a maximum benefit of $300. Naturally occurring hair loss is not considered illness or injury for this benefit.
14. Diabetic instruction (including nutritional counseling) limited to a maximum benefit of $100 per lifetime.

Other Medical Benefits

-Preventive Care Benefits

Routine physical exams and related x-rays and lab work, flu shots, pap tests, routine mammograms and PSA tests for detection of prostate cancer *are covered up to the Plan's calendar year maximum* (see your *Summary of Coverage*).

-Skilled Nursing or Convalescent Care Facility

Room and board in a convalescent care or skilled nursing facility (see *definition*, page 51) is limited to the first 60 days as a registered inpatient, as long as this alternative treatment plan is pre-approved by Blue Cross Life and Health. Purely custodial care is not covered.

The hospital stay must begin within seven days after hospitalization of at least five days, unless alternative care is pre-approved by Blue Cross Life and Health (see *Case Management* on page 19).

All periods of convalescent hospital confinement during any single disability period are considered one hospital stay.

Benefits for convalescent hospitalization shall not be higher than the facility's standard charge for a standard semi-private room. Benefits are not paid for custodial care or for services that are not pre-approved by Blue Cross Life and Health.

-Mental Health Services

Inpatient and outpatient mental health services are covered to the same extent as any physical illness subject to the overall medical lifetime maximum (listed in your *Summary of Coverage*) and the following limitations:

- **Inpatient Days Maximum.** Covered expenses for in-hospital mental health services are limited to the maximum days per calendar year shown in your *Summary of Coverage*.
- **Outpatient Per Visit Maximum.** Covered expenses for out-of-hospital mental health services are limited to the per visit covered expense maximum (listed in your *Summary of Coverage*).

-Chiropractic Treatment Benefits

The Plan pays for medically necessary chiropractic treatment provided by a licensed doctor of chiropractic medicine up to the per visit and calendar year maximums listed in your *Summary of Coverage*.

- The initial consultation and diagnostic x-rays do not count against the chiropractic maximums since they are payable as other medical expenses and subject to the calendar year deductible.
- There is a separate maximum per covered person per calendar year for treatment of muscle spasms, strain or other soft tissue conditions (as explained in your *Summary of Coverage*).
- Supplements and supplies are not covered.
- Massage therapy is not covered.

-Alcohol or Chemical Dependency Treatment Benefits

Alcohol or chemical dependency at an approved inpatient residential detoxification and treatment facility or a licensed Chemical Dependency Recovery Hospital (CDRH) is subject to the following requirements:

1. The inpatient residential facility or CDRH must be authorized and monitored by the Teamsters Assistance Program (TAP) if you are not covered by Medicare.
2. An inpatient or outpatient course of treatment for rehabilitation of *alcohol or drug abuse* is paid subject to the covered expense maximum listed in your *Summary of Coverage*.
3. An *inpatient or outpatient course of treatment* is an alcohol or chemical dependency rehabilitation treatment that begins on the day you enroll and ends on the earlier of the following:
   - The date you are discharged by the facility or program as having fulfilled the course of treatment, or
   - The date you end treatment without authorization from the TAP program.

Benefits are paid for a maximum of one course of treatment per lifetime (whether inpatient or outpatient).

The treatment is paid at 100% up to the covered expense maximum stated in your *Summary of Coverage*.

- Benefits for emergency treatment related to *alcohol or chemical dependency* in an acute care hospital are paid the same way as treatment for any other illness.
- Benefits for inpatient substance abuse recovery programs in an acute care hospital are limited in all cases to the maximum covered expense amount listed in your *Summary of Coverage*.

-Stop-smoking Benefits

The Indemnity Medical option provides stop-smoking benefits to help participants and their covered spouses quit smoking.

> **IMPORTANT**
> *HMO participants are eligible for the stop-smoking benefits explained in this guide, in addition to any stop-smoking benefits available through the HMO.*

How Stop-smoking Benefits Work.

TBT reimburses up to $50 toward a stop-smoking program offered through the American Cancer Society, American Lung Association, one of the Plan's PPO hospitals or an HMO (if the HMO requires a copayment for its program) if you successfully complete the program and remain tobacco-free for at least six months. Only one stop-smoking program is covered per lifetime.

Doctor's Office Visit

An office visit related to use of nicotine patches is covered in the same way as other doctors' office visits.

Nicotine Patches.
TBT reimburses 50% of the cost of nicotine patches whether or not prescribed by your doctor—up to a $150 lifetime maximum—subject to the conditions listed below. Since nicotine patches are considered to be most effective when used with a stop-smoking program, both requirements must be met before benefits are reimbursed:

1. You successfully complete a stop-smoking program through the Plan.
2. You remain tobacco-free for at least six months.

Note: *Since nicotine patches no longer require a doctor's prescription, TBT reimburses covered charges based on the itemized receipts.*

Reimbursement Steps. Once you complete a stop-smoking program through the American Cancer Society, American Lung Association, PPO hospital or your HMO, send the following to the TBT Plan Administration Office:

1. Itemized receipt for nicotine patches.
2. A receipt for the cost of the stop-smoking program and a certificate of successful completion.
3. A written statement that you have been tobacco-free for six months or longer.

Call the TBT Plan Administration Office if you have questions about stop-smoking benefits.

-Special Transplant Provisions

Charges resulting from or directly related to any attempted or completed transplant procedure that is experimental in nature (whether involving human, animal or man-made organs) are not covered by the Plan.

Certain human organ or tissue transplants from a living donor to a transplant recipient requiring surgical removal of a donated part *are* covered, subject to the following conditions:

1. Benefits will be provided only when the hospital and doctor customarily bill a transplant recipient for such care and services.
2. When the transplant recipient is a covered person, benefits are provided only for the recipient.
3. When the transplant recipient is not a covered person, and the donor is covered, the donor receives benefits for care and services necessary to the extent such benefits are not provided by any coverage for the organ or tissue transplant procedure available to the recipient. The benefits are payable up to the Plan's maximum amount for these services, as described in your *Summary of Coverage*.
4. Benefits are not provided to any recipient or donor who is not covered by the Plan.
5. When the transplant recipient and the donor are both covered persons under a TBT Plan, benefits are provided in keeping with the limits of their respective Plans.

MEDICAL BENEFITS FOR MEDICARE PARTICIPANTS

This section explains your medical benefits through the Indemnity Medical option for Medicare-entitled or eligible participants. Also see *About This Plan and Medicare* on page 13.

You'll also need to check your *Summary of Coverage* for specific information about the Plan, such as the calendar year deductible, copayment percentages and special benefits. If you have coverage through an HMO offered by TBT, those benefits are explained in separate material from the HMO. Contact the TBT Plan Administration Office to request an HMO enrollment packet.

Contact your local Social Security Administration Office for information about Medicare coverage. It is listed in your local telephone directory.

You may also receive *Plan Change Notices* or a *Summary of Material Modifications* explaining important changes to your coverage. Keep these notices in this package so you can refer to the most current information about your benefits.

ABOUT MEDICARE

Medicare benefits are available in two parts: Part A is usually free of charge and provides hospital benefits. Part B provides supplemental medical insurance and requires a monthly premium. The Plan integrates benefits with Medicare as if you are enrolled in both parts. ***If you are eligible for Medicare Parts A and B, but do not enroll, TBT pays covered expenses as if you were enrolled in Medicare.*** *In general, the Plan pays a* ***maximum benefit of 20% of the Medicare-approved amount for expenses that would otherwise be covered by Medicare****.*

If you are entitled to Medicare, Medicare pays first (as the primary carrier) and the Plan pays second (as the secondary carrier). The Plan pays Medicare deductibles and copayments at the percentages listed in your ***Summary of Coverage****, after you have satisfied the Plan deductible.* ***The Plan integrates benefits with Medicare Parts A and B and does not cover charges higher than Medicare-approved amounts****.*

See page 28 for information about Medicare Part D.

What is Covered for Medicare Participants

Medicare is the primary source of medical benefits and pays first (as the primary carrier) and the Indemnity Medical option pays second (as the secondary carrier). *The Plan integrates benefits with Medicare* and does not cover charges that are higher than the Medicare-approved amounts.

Covered expenses are the same for participants who are entitled to Medicare and those who are not (see *Covered Expenses* on pages 19-22 and *What is Not Covered* on pages 24-25). However, you should be aware that certain features under the Indemnity Medical option that apply to your coverage *before* you are Medicare-entitled no longer apply *after* you are enrolled in Medicare:

- ***Hospital Benefits:*** In general, Medicare Part A provides 100% coverage for hospital benefits after you pay the Medicare hospital deductible. The Plan pays Medicare deductibles after you satisfy the Plan's calendar year deductible.
- ***The Plan's Hospital Pre-admission Certification, Utilization Review, Case Management, Preferred Provider Organization (PPO hospital, physician or other provider) and Teamsters Assistance Program (TAP) procedures are not required.*** Once you are age 65 or otherwise entitled to Medicare, benefits are determined by Medicare.
- ***Outpatient Hospital and Physician Charges.*** Medicare Part B covers outpatient hospital and doctors' services. Medicare's Part B schedule reflects the amounts that Medicare believes are reasonable charges for specific services, (the amount *assigned* by Medicare). Many doctors and other providers agree to *take assignment*. This means that they will accept the Medicare-approved amounts as payment in full. It is to your advantage to seek services from a doctor and other providers who take assignment.

The Indemnity Medical option generally covers 20% of the Medicare scheduled amounts for Part B services after the Plan's calendar year deductible is satisfied. Your share of the cost for these services depends on whether or not your doctor takes assignment (as explained above). If your provider does not take assignment and charges are higher than allowed under the Medicare Part B schedule, your out-of-pocket costs go up.

> ***Example:*** *Your doctor charges $1,000 for a covered procedure and the Medicare-approved amount is $800. Medicare pays $640 (80% of $800) and the Plan pays $160 (the balance of the Medicare-approved amount). If you use a doctor who* ***takes assignment****, the remaining $200 is not your responsibility and is not a covered expense. If the doctor does not take assignment, you are responsible for the remaining $200. (This example assumes that you have already met the Plan's calendar year deductible and that all other Plan requirements have been met. It also assumes that the Plan has paid the Medicare deductibles after the Plan deductible is satisfied.)*

- ***The Plan pays Medicare deductibles and the balance of the Medicare-approved amount not paid by Medicare,*** after you satisfy the Plan's calendar year deductible explained in your *Summary of Coverage*.
- ***The Plan pays for certain benefits otherwise covered by the Plan that may not be covered by Medicare*** (such as physical exams or stop-smoking benefits). When this happens, the Plan pays its normal benefit as if you were not yet entitled to Medicare. Any amounts payable by Medicare are subtracted from amounts payable by the Plan.
- ***Once you are entitled to Medicare,*** Medicare pays benefits first (as the *primary* carrier) and the Plan pays second (as the *secondary* carrier). You send your claims to Medicare *before* sending them to the TBT Plan Administration Office (see *Medicare Part D* on page 28).
- ***Medicare HMO Participants:*** Prescription drug benefits are provided by the HMO rather than by TBT.

The Deductible

The deductible is the amount you pay each calendar year before medical benefits are payable. The deductible amounts are listed in your *Summary of Coverage*. Both you and your covered spouse pay separate calendar year deductibles for covered medical expenses.

WHAT IS NOT COVERED

Limitations and Exclusions

The Indemnity Medical option covers only treatment, services or supplies that are *medically necessary and prescribed by your doctor*. The following expenses are *not* covered (regardless of whether you are entitled to Medicare):

1. Expenses that are not medically necessary for the care or treatment of bodily injuries or illness.
2. Services or supplies that are not provided under the supervision of a doctor (or other Plan-approved provider) operating within the scope of an appropriate license.
3. Charges higher than Usual, Customary and Reasonable (UCR) amounts—as determined by the Board of Trustees. Unless otherwise provided, covered charges may not be higher than UCR charges for covered services and supplies in the geographic area where they are provided.
4. Charges above the covered person's calendar year maximum for preventive care benefits such as routine physical exams and related x-rays and lab work, flu shots, pap tests, routine mammograms and PSA tests for detection of prostate cancer. See your *Summary of Coverage* for the Plan's calendar year maximum. **Note:** *Diagnostic charges are not subject to the preventive care maximum.*
5. Cosmetic surgery, unless required (1) to repair or alleviate damage caused by an accident provided that surgery takes place within two years of the accident and while still eligible; or (2) in connection with a mastectomy, to reconstruct a breast on which a mastectomy has been performed, to reconstruct the other breast to produce a symmetrical appearance, or for prostheses and physical complications in all stages of a mastectomy.
6. Dental services and supplies *unless* the expense is necessary for repair or alleviation of damage to natural teeth caused by an accident that occurs while covered under the Plan if surgery takes place within two years from the date of the accident *and* while still eligible.
7. Expenses incurred for prescription drugs and medicines except while hospitalized. (Prescription drugs and medicines are provided through the Prescription Solutions prescription drug program, including *take-home* drugs and medicines. See *Prescription Drug Benefits* beginning on page 26.)
8. Drugs and medicines dispensed in a doctor's office except covered injections provided during a doctor's office visit.
9. Weight control and nutritional counseling *except* when prescribed to treat a specific medical condition or for morbid obesity with disease etiology.
10. Any charges that result from or are related to any medical or surgical procedure that is considered experimental in terms of generally accepted medical standards as determined by the Plan.
11. Any charge related to the treatment of infertility, including but not limited to artificial insemination, *in vitro* fertilization, reversal of tubal ligation or vasectomy or any form of assisted reproductive technology.
12. Intentionally self-inflicted injuries, unless the injury results from a medical condition.
13. Conditions caused by or related to an act of war, armed invasion or aggression.
14. Conditions caused by participating in a riot or committing a felony.
15. Any accidental bodily injury or illness caused by or during the covered person's employment or in connection with illness or injury for which the person is entitled to benefits under any Workers' Compensation or occupational disease law. (For conditional advance payment related to an assignment of benefits, see *Recovering Benefits from a Third Party* on page 37.)
16. Any condition for which care or treatment is obtained from a federal, state or government agency or program where care is available without cost to the person. This includes any care provided by a hospital or facility owned or operated by governmental or state entities (unless there is an unconditional requirement to pay for this care without regard to the rights of others, contractual or otherwise).
17. Any medical services or supplies provided by or paid for by any governmental program (federal, state, county, district or municipal). This includes expenses that are payable by Medicare Parts A, B or D.

18. Charges that are higher than would otherwise be billed for the same care if benefits were not provided under the Plan. The Plan does not pay expenses that it is not obligated to pay (for example, expenses covered by an HMO for which no charge would otherwise be made to the patient or that the patient is not legally obligated to pay).
19. Any charges that would not be made in the absence of this coverage.
20. Charges for itemized reports or itemized billing, except when requested by the Plan.
21. Charges for failure to keep a scheduled appointment.
22. Charges for services incurred before coverage was effective.
23. Services that are custodial in nature, rather than professional medical services prescribed by a doctor.
24. Nursing services provided by a family member or someone who lives in your home.
25. Any services related to *Pain Centers* or pain treatment clinics (even if prescribed by a doctor) including, but not limited to, biofeedback, hypnotism or the purchase or rental of any durable medical equipment related to such pain treatment.
26. Purchase of durable medical equipment unless such purchase is determined appropriate by TBT in advance and specifically pre-authorized by the Plan's Utilization Review Organization.
27. Charges for equipment such as water or air purifiers, vacuum cleaners or other household appliances, Jacuzzi pools or exercise equipment, even when prescribed by a physician for therapeutic purposes.
28. Speech therapy, occupational therapy or vision therapy, except when prescribed by a doctor to treat an illness or injury.
29. Charges related to treatment for change of gender and/or any complications resulting from such treatment.
30. Procedures, services or supplies specifically excluded by the Plan now or in the future.
31. Vitamins, *including vitamin injections*, even when prescribed (unless medically necessary as determined by Blue Cross Life and Health, the Plan's Utilization Review Organization).
32. Sales tax.
33. Ambulance, including air ambulance, when not appropriate for the level of medical treatment required or solely for convenience.
34. Waterbeds or flotation beds.
35. Charges for any services relating to *alternative medicine*. This term refers to holism, homeopathic treatment, orthomolecular services and any other treatment of a similar kind.
36. Hypnotism.
37. Support stockings, except for initial pair prescribed by a doctor following surgery.
38. Orthotics, except for the initial pair prescribed by a doctor.
39. Treatment of Temporomandibular Joint Dysfunction (TMJ).
40. Hearing aids and related expenses.
41. Eyeglasses, lenses, eye refractions.
42. Radial Keratotomy (RK) and any other form of eye surgery intended to correct nearsightedness or astigmatism.

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 30) for details about claim filing and appeals procedures.

PRESCRIPTION DRUG BENEFITS

Prescription Solutions administers your TBT prescription drug benefits. To get the most from your coverage, you should use your prescription drug card at a participating pharmacy. Prescription Solutions has a network of thousands of participating pharmacies, including most retail pharmacies and drugstore chains. Contact Prescription Solutions at (800) 797-9791 to confirm that your pharmacy is in the network. Or visit their web site at www.rxsolutions.com.

When Coverage Begins

You and your covered spouse become eligible for prescription drug benefits at the same time that you are eligible for your other TBT benefits (see pages 2-5).

DRUG BENEFITS FOR HMO PARTICIPANTS

For most TBT Plans, prescription drug coverage is provided by TBT even if you choose an HMO. However, if you are enrolled in a ***Medicare HMO Plan****, prescription drug benefits are provided by that HMO rather than through the TBT prescription drug benefits. See the enclosed* ***Comparison of Medical Benefits*** *and* ***Summary of Coverage*** *for details. Also check the HMO* ***Evidence of Coverage*** *for information about your HMO option.*

Prescription Drug ID Card

When the TBT Plan Administration Office receives your *TBT Retiree Enrollment Form*, Prescription Solutions sends you a welcome package that includes program instructions, prescription drug ID cards and a mail service brochure. Your prescription drug ID card lists only your name but may also be used by your covered spouse. If your spouse is covered under the Plan, you are sent two prescription drug ID cards.

For newly eligible participants, a temporary prescription drug ID card is enclosed with this *Guide to Your Benefits* and may be used until you receive your ID cards from Prescription Solutions.

If you need an additional Prescription Solutions prescription drug ID card, you can request one by calling the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

What is Covered

The Plan's prescription drug benefits provide up to a 100-day supply of covered drugs or medicines prescribed by a licensed doctor or dentist to treat an illness or injury. Be sure to check additional restrictions on page 29. Also review your *Summary of Coverage* for information about copayments (if any) that may apply to your prescription drug benefits.

The Plan covers most medicines and drugs that are; (1) prescribed under federal and state laws by a licensed doctor or dentist; (2) medically necessary for the patient's illness or injury; (3) fully approved by the U.S. Food and Drug Administration (FDA); and (4) not contained in the list of exclusions on page 29 of this guide. The most common prescription drug items covered include:

- Federal-legend drugs.
- State-restricted drugs.
- Compounded medications.
- Insulin on prescription.
- Needles and syringes on prescription.
- Injectables, Imitrex (including auto-injector).
- Federal-legend oral contraceptives.
- Norplant.
- Prenatal vitamins (during pregnancy).
- Diabetic supplies (except machines such as a glucometer).

There is no drug "formulary" (list of included/excluded drugs) and the only criteria regarding whether an existing or new drug is covered by the Plan is (1) full approval by FDA (2) included under *What is Covered* above or (3) excluded under the heading *What is Not Covered* on page 29. However, the Board of Trustees reserves the right to adopt a formulary in the future if it deems necessary.

If you are not sure whether an item is covered, call Prescription Solutions at (800) 797-9791.

Pre-Approval by Diagnosis

The following are covered only when *pre-approved by the Plan's Utilization Review Organization for an FDA-approved diagnosis.*

- Immune altering drugs.
- Genetically engineered drugs.

(See *What is Not Covered* on page 29.)

Mail Service Program

If you need to fill a three- or six-month supply of maintenance drugs, you now have the option to use the mail service program. The medicine is mailed directly to your home.

The same restrictions and exclusions that apply to the prescription drug card program also apply to the mail service program. If you need a mail service form or information, contact the TBT Plan Administration Office.

If You Need Injectable Medications

Most injectable medicines (except Insulin and those listed below) are only covered when filled through Prescription Solutions' mail order Specialty Pharmacy Program and are restricted to a 30-day supply.

Note: This does not apply if you are enrolled in a TBT Plan that requires you to use the Kaiser pharmacy only for your prescriptions, or if injectable drugs are covered under your HMO plan. Contact the HMO for details about injectable prescription drugs and medicines.

Injectable Exceptions. The following commonly used injectable medications may be purchased at the retail pharmacy under the regular card program, with up to a 100-day supply:

- *Arixtra*
- *Cyanocobalamine*
- *Delatestryl*
- *Delestrogen*
- *Depo-provera*
- *Depo-Testosterone*
- *Dexamethasone*
- *Furosemide*
- *Fragamin*
- *Haloperidol Lactate*
- *Heparin*
- *Innohep*
- *Insulin*
- *Lidocaine*
- *Lorazepam*
- *Lovenox*
- *Lunelle*
- *Methotrexate*
- *Nubain*
- *Progesterone*
- *Promethazine*
- *Sodium Bicarbonate*

To order injectable medications that are not contained on the list above, you must use the Prescription Solutions *Specialty Pharmacy Program*. Your doctor sends a request to *Prescription Solutions* for your injectable drugs by faxing a *Prior Authorization Form* to Prescription Solutions at (800) 853-3844 —or by calling them at (800) 711-4555. Once the request is authorized, Prescription Solutions contacts you or your doctor to coordinate the delivery.

Your order is shipped to your home or the doctor's office or clinic at no charge. All orders are sent via UPS overnight delivery to arrive Tuesday through Friday only.

Since all injectables are limited to a 30-day supply, a patient care coordinator will contact you to refill your prescription before it runs out.

If you have questions about the Specialty Pharmacy Program or covered injectable medicines, contact their help desk at (800) 562-6223. If you have other questions or need help, contact the TBT Plan Administration Office and ask for the Pharmacy Unit.

Use Generic Drugs

The Plan encourages you to ask your doctor to prescribe generic drugs instead of brand name drugs (when a generic equivalent is available). If for any reason you or your doctor choose a brand name drug when a generic equivalent is available, the Plan pays for the brand name drug, but only up to the cost of the generic equivalent (after any applicable copayments are collected).

IMPORTANT

If you (or your doctor) order a brand name drug when a generic equivalent is available, you'll pay the cost difference—in addition to any copayment you may need to pay under your TBT prescription drug benefits. (See your ***Summary of Coverage*** *for details.)*

How to Use the Program

The program is easy to use. Present your prescription drug card whenever you fill a prescription at a participating pharmacy. The pharmacy checks your eligibility and coverage status in the Prescription Solutions database, bills the claim electronically, fills your prescription and collects the copayment.

If you need help locating a Prescription Solutions pharmacy, call the toll-free customer service number at (800) 797-9791 from 6:00 a.m. to 9:00 p.m. P.S.T.

You and your covered spouse must use this card at a Prescription Solutions pharmacy to receive maximum prescription drug benefits (see *Using Non-participating Pharmacies* on page 28).

When You First Become Eligible

If you need to fill a prescription after you become eligible, but *before* you receive your Prescription Solutions ID card, you can use a Prescription Solutions *Direct Member Reimbursement Claim Form*. The TBT Plan Administration Office can also send you a form upon request.

Note: Send your completed *Direct Member Reimbursement Claim Form to* Prescription Solutions at the following address:

Prescription Solutions
Mail Stop LC07-290
Attn.: Claims Department
P.O. Box 6037
Cypress, CA 90630-0037

Include the prescription label receipt (which *must* include the following information, or payment could be delayed or denied):

- *Pharmacy name*
- *Prescription number*
- *Fill date*
- *Name of physician*
- *Drug name*
- *Strength, quantity and amount paid*

New participants, during their first month of eligibility, will be reimbursed at 100% of the incurred cost for covered drugs or medicine (minus any copayment that may apply—see your *Summary of Coverage*).

Using Non-participating Pharmacies

If for any reason you use a non-participating pharmacy, you pay the full cost of the prescription up-front and are reimbursed once you send Prescription Solutions a completed *Direct Member Reimbursement Claim Form* (explained below).

You are reimbursed at the rate that Prescription Solutions would pay to a participating pharmacy, which is usually *less* than retail charges at non-Prescription Solutions pharmacies (minus any copayment that may apply as explained in your *Summary of Coverage*).

Fill out your portion of the Prescription Solutions *Direct Member Reimbursement Form*. Your pharmacist must fill out the bottom section. Send the completed form to Prescription Solutions at the address printed on the form.

MEDICARE PART D

If you are Medicare-eligible but enrolled in the CRP, do not enroll in a Medicare Part D program. ***If you enroll in a Medicare Part D program, you will lose your TBT prescription drug coverage.***

Indemnity Plan Prescription Drugs If Medicare-entitled

Medicare Part D: If you or your spouse are Medicare-entitled, Prescription Solutions automatically enrolls you in their Medicare Part D Prescription Drug Plan (PDP). They also send you a new ID number and prescription drug card. See the *Summary of Coverage* or your Prescription Solutions member packet for details. *Do not enroll in a Medicare Part D program or you will lose your Prescription Solutions coverage.*

Medicare Part D is the primary payer for Medicare-allowable prescription costs after the applicable Medicare copayment. Medications that are not Medicare-allowable may be covered under the Prescription Solutions program minus a 30% copayment. TBT follows the days supply allowed by Medicare Part D.

Note to Medicare HMO Participants

Prescription drug benefits are provided by the HMO rather than by TBT. See the *Comparison of Medical Benefits* and the HMO's *Evidence of Coverage* for details.

WHAT IS NOT COVERED

The following drugs or medicines are *not* covered:

1. Those administered or billed by a hospital or nursing facility related to inpatient services or not dispensed by a licensed pharmacist.
2. Those received without charge through local, state or federal programs including Workers' Compensation.
3. Those legally available without a prescription, except insulin and insulin syringes when prescribed by a physician.
4. Nicotine patches (unless after completion of a Plan-approved stop-smoking program—see pages 21-22).
5. Nicorette gum.
6. Lost or stolen medication.
7. Cosmetics, health and beauty aids or drugs prescribed for cosmetic purposes and not medically necessary (such as Retin-A).
8. Charges higher than what is Usual, Customary and Reasonable (UCR).
9. Vitamins (including federal-legend vitamins) even when prescribed—unless medical necessity is clearly established.
10. Anabolic steroids.
11. Growth hormones (unless pre-approved by the Plan's Utilization Review Organization).
12. Fertility drugs.
13. Viagra and any other drugs for the treatment of impotence, unless medical necessity is clearly established as determined by the Plan's Utilization Review Organization.
14. Allergy serums.
15. Genetically engineered drugs and immune altering drugs (even when injectable) if not pre-approved by the Plan's Pre-certification and Review Organization.
16. Immunization agents, biological sera or plasma.
17. Diet medications, appetite suppressants, dietary or nutritional supplements and liquid diet food which may be purchased with or without a prescription.
18. Therapeutic equipment, devices or appliances, whether or not prescribed by a doctor—including hypodermic needles, syringes, support garments and other non-medical items. In some cases, these items may be covered under your TBT medical option (see *Other Covered Expenses*, number 7 on page 20).
19. Charges for an unreasonable supply of drugs (or more than the maximum 100-day supply).
20. Refills not authorized by the prescribing physician.
21. Refills requested sooner than appropriate after last filled.
22. Drugs or medicines dispensed a year or more after the prescription date.
23. Claims not filed within one year of purchase.
24. Prescriptions filled before coverage begins or after it ends.
25. Drugs or medicines prescribed for conditions or treatments not covered by the Plan.
26. Investigational or experimental drugs.
27. Charges to administer prescription drugs or insulin injections.
28. Drugs or medicines that have not been fully approved by the U.S. Food and Drug Administration (FDA).
29. Compounded medications that are not FDA-approved. **Note:** Compounded medications must be reviewed by Prescriptions Solutions.
30. Off-label uses of FDA-approved drugs are not covered.
31. Charges for research or for experimental medications.

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 30) for details about claim filing and appeals procedures.

CLAIMING BENEFITS

When you have a covered expense, it is not always necessary to file a claim. In many cases, the provider handles all the paperwork.

Claim Filing

You rarely need to file a claim for the following benefits:

- ***HMO benefits.*** When you use HMO facilities in your usual service area (see the *HMO Evidence of Coverage* for more information).
- ***Prescription Solutions prescription drug benefits.*** When you use Prescription Solutions participating pharmacies.
- ***Prescriptions when you are enrolled in a Medicare HMO.***

You usually need to file a claim for the following benefits:

- ***HMO benefits.*** When you travel or receive benefits outside your usual HMO service area (see HMO materials for more information).
- ***Prescription drug benefits PPO.*** If you are a new participant, before receiving your prescription drug card (unless you use the temporary ID provided by the TBT Plan Administration Office) or if you use a non-Prescription Solutions pharmacy. Separate claim forms are required for you and your covered spouse. (See *When You First Become Eligible* on page 28.)
- Ask your doctor or other provider to send itemized claims to the TBT Plan Administration Office. If they do not file a claim, claim filing is your responsibility.
- Anthem Blue Cross PPO hospital claims must be sent directly from the hospital provider to Blue Cross (following instructions found on the back of the Blue Cross ID card).
- ***Medicare.*** If you are Medicare-entitled, you file all medical claims with Medicare before you file for reimbursement under the Indemnity Medical option (explained on page 22).
- ***Non-Medicare.*** Claims must always be filed for Indemnity Medical benefits (explained next), regardless of whether you use a PPO or non-PPO hospital, doctor or other provider. The provider *usually* sends the claim to the TBT Plan Administration Office. Hospitals always handle claim submission (by sending claims directly to Anthem Blue Cross PPO). *You should ask your doctor or other provider to send in the claim following instructions found on the back of the Blue Cross ID card.* If they do not send in the claim, it is your responsibility to send the claim to the TBT Plan Administration Office.

How to File an Indemnity Medical Claim If Not Medicare-entitled

1. If you need to file an Indemnity Medical claim, you need to get the appropriate form through the TBT Plan Administration Office. A claim form is enclosed in your *Forms* folder.
2. Fully complete and sign your portion of the form.
3. Where applicable, have the provider (doctor, hospital or other provider) complete the rest of the form or provide an itemized bill that contains the requested information. It is your responsibility to send the itemized claim forms to the TBT Plan Administration Office.
4. Mail the completed form with any related bills or statements to the address printed on the claim form within 90 days of the date the claim was incurred. *In no event except the loss of legal capacity will a claim be accepted and processed later than 12 months after the claim was incurred. If you don't provide all the requested information and itemized receipts, your claim will be delayed.*

MEDICARE CLAIM FILING

When you are entitled to Medicare, you must apply for Medicare Parts A and B coverage through your local Social Security Administration office. If you are eligible for Medicare Parts A and B coverage and do not apply, ***all TBT claims are processed as if you have Medicare benefits****. The Plan will only allow a maximum benefit of 20% of the Medicare-approved amount (after deductibles have been met) on any claim that would otherwise be covered by Medicare Parts A and B.*

How to File an Indemnity Medical Claim If Medicare-entitled

1. If you are Medicare-entitled, you must file your claims with Medicare *before* you file your claims under the Indemnity Medical option. Usually, your medical provider helps complete these forms for you. You can get the appropriate form through your doctor or hospital.
2. Make sure that the claims are completed and sent to Medicare, as requested.
3. Where applicable, have the provider (doctor, hospital or other provider) complete a portion of the form or provide an itemized bill that contains the requested information.
4. Medicare provides payment and issues an explanation of how your benefits were computed. You should send copies of the Medicare explanation of benefits and itemized bills along with your claim form to the TBT Plan Administration Office as explained above. If you don't provide all the requested information and itemized receipts, your claim is delayed.

Late Claims

If you do not file a claim within the 90-day deadline, the claim will not be reduced or denied if you can show that there was a reasonable cause for the delay. In this case, notice of proof must be provided as soon as reasonably possible. However, in no event, except in the absence of the claimant's legal capacity, shall a claim be accepted later than one year from the date when services were first received.

Claim Payment Process

If you are enrolled in an HMO offered through TBT, these organizations have their own procedures for claim filing and appeals.

All other claims, including Pre-service claims, Concurrent Care Claims, Post-service claims, and claims concerning eligibility are subject to the procedures explained on the next few pages.

Types of Claims

A claim is any request for Plan benefits made in keeping with the Plan's claim filing procedures. Inquiries about Plan provisions unrelated to a specific request for benefit coverage or concerning whether you are eligible for coverage under a TBT Plan are not claims covered by the procedures described in this guide. However, if you file a claim for benefits that is denied because you were not eligible for Plan coverage, that denied claim *is* a "claim" for purposes of the procedures described in this guide. A request for benefits does not qualify as a "claim" unless all of the following information is included in your *claim* form:

- Your name.
- The patient's name (yours or your covered spouse's).
- Patient's birth date.
- Your Social Security number.
- The date of service.
- The applicable CPT Code for any treatment (the Code for physician and other medical services).
- Billed charges.
- Number of units (for anesthesia and certain other types of claims).
- Federal Taxpayer ID of provider.
- Billing name and address of provider.
- If treatment is the result of an accident, details concerning the accident, and
- Information on any other insurance that may apply.

IMPORTANT TERMS

Claim Concerning Eligibility: *A Pre-service or Post-service Claim that concerns the eligibility for benefits of the claimant as a Plan participant or covered spouse.*

Pre-service Claim: *A claim that is not covered by the Plan unless you have asked for and received the Plan's approval before you receive treatment or care of any kind.*

Urgent Care Claim: *Any claim for medical care or treatment which, if processed according to the ordinary time limits for Pre-service Claims, (1) could seriously jeopardize your life, your health, or your ability to regain maximum function, or (2) in the opinion of the doctor who has knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment described in your claim.*

Concurrent Care Claim: *A claim that is subject to reconsideration after initial approval and benefits are reduced, terminated or extended. For example, if TBT's medical review organization, Blue Cross Life and Health, approves a course of 10 treatments over three months, and after seven treatments, TBT's medical review organization determines that the remaining treatments initially approved are no longer necessary, and you or your doctor disagree, your claim is a Concurrent Care Claim subject to the filing procedures beginning on page 33.*

Post-service Claim: *Any claim other than a Pre-service Claim, Urgent Care Claim or Concurrent Care Claim.*

Filing Pre-service Claims

No benefits are payable unless you have received approval before treatment for the following types of admissions and claims:

- *Hospital Admission for Non-urgent Care*

  Blue Cross Life and Health, the Plan's Pre-admission Review and Utilization Review Organization, must approve any hospital admission—*except urgent care admission*—before you go to the hospital. If you are age 65 or older or Medicare-entitled, pre-authorization for hospital confinements is not required, except for treatment of *alcohol or chemical dependency* (explained below).

- *Hospital Admissions for Urgent Care*

  You (or your doctor) will receive notice of the Plan's decision on your claim within 72 hours after all required information has been received.

If your Urgent Care Claim is received with insufficient information to determine what benefits are covered or payable, the Plan's Pre-admission Review and Utilization Review Organization will notify you and your doctor as soon as possible, but not later than *24 hours* after receipt of the claim concerning what is needed to complete review of the claim. You (or your doctor) must respond within *48 hours* with the information requested or your claim will be denied. You (or your doctor) will receive notice of the Plan's decision on your claim within *48 hours* after receipt of the requested information.

- Treatment for *Alcohol or Chemical Dependency*: The Teamsters Assistance Program of Northern California (TAP) must preauthorize any claim. TAP can be reached at (510) 562-3600 or (800) 253-TEAM.
- Home Care or Alternative Treatment of any kind.
- Convalescent Hospital, Skilled Nursing Facilities or Hospice care.

For pre-authorization of hospital admissions, home or alternative care or hospice care, you (or your doctor) must call Blue Cross and Health at (800) 274-7767.

The TBT Plan Administration Office (and TBT's medical review organizations) respond to Pre-service Claims within the following timelines: Within *15 days* for non-urgent Pre-service claims (in cases where more time is required, they have *15 additional days to respond*, in which case you are notified why more time is required and when you can expect a reply).

If your claim is not for urgent care and the Plan needs more time to process your claim because it needs more information from you or your doctor, you and your doctor have up to *45 days* to supply this information from the date of receipt of the Plan's notice. If you do not supply this information on time, your claim will be denied. After receipt of the information needed from you or your doctor, the Plan will respond to your claim within *15 days*.

Filing Concurrent Care Claims

Claims for reconsideration of a concurrent care claim that involves the termination or reduction of a previously approved hospitalization or course of treatment should be filed with the TBT Plan Administration Office and is then referred to the appropriate review organization. For medical claims, the claim is referred to Blue Cross Life and Health; for alcohol or chemical dependency treatment, to TAP.

Your claim for reconsideration is decided as soon as possible and early enough to allow you to appeal the decision on reconsideration before benefits are reduced or terminated. You will receive notice of the Plan's decision on Concurrent Care Claims that also qualify as Urgent Care Claims within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of the prescribed series of treatments.

Filing Post-service Claims

If your Post-service Claim is complete, you are notified of the decision concerning the claim within *30 days* of receipt, but the Plan can extend that deadline by an additional *15 days* if more time is needed. If more time is needed, you are notified before the end of the *initial 30 days* about why the Plan needs additional time and when you can expect to receive a decision on your claim. If more time is needed because you need to submit more information, you have *45 days* from receipt of the Plan's notice to supply the requested information. If you do not provide the requested information within *45 days*, your claim will be denied. After receipt of the requested information, the Plan will make a decision on your claim within *15 days*.

Appealing a Denied Claim

Adverse Decision. If the Plan denies, reduces, terminates, or fails to provide or make payment (in whole or in part) for a benefit, you will be sent a *Notice of Adverse Decision* that will include the following:

- The specific reason(s) for the adverse decision.
- Reference to the specific Plan provision(s) on which the adverse decision is based.
- A statement about your rights to bring a civil action under ERISA following an adverse decision on an appeal or the denial of your claim.
- If applicable, a description of any additional material or information needed to make a full and complete claim, and the reason why it's needed.
- A statement that you will be provided upon request and free of charge reasonable access to any copies of any records or documents in the Plan's possession relevant to your appeal.
- A statement that you will be provided upon request and free of charge a copy of any internal rule, guideline or protocol that was relied on to decide your claim.
- For adverse decisions based on the absence of medical necessity of the use of experimental or investigational treatment (or any similar reason), a statement that you will be provided upon request and free of charge an explanation of the scientific or clinical judgment for the determination as applied to the Plan and your claim.
- An explanation of the Plan's appeal procedures and time limits.
- You and the Plan may have other voluntary alternative dispute resolution options such as mediation. One way to explore the options available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Appeal of an Adverse Decision

If you disagree with the decision on your initial claim, you (or your Authorized Representative) may file a **written** appeal within *180 days* after your receipt of the Notice of Adverse Decision. You may, however, appeal an adverse decision regarding Urgent Care Claims by writing the TBT Plan Administration Office. You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in court).

If your appeal concerns a claim for urgent care, you can appeal by phone by calling the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

The Plan's Board of Trustees will make the decision on appeal. They will not defer to the initial adverse benefit determination and will consider all comments, documents and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made on the basis of the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board of Trustees will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board of Trustees did not rely on this advice in making its decision).

Adverse Decision on Appeal. If you appeal an adverse decision, you will receive a Notice of Adverse Decision on Appeal that will contain all of the information listed above concerning your appeal (except the appeal procedures and time limits).

You will receive notice of the decision on your appeal within *72 hours* for Urgent Care Claims and within *30 days* for other Pre-service Claims. Appeals of Post-service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within *30 days* of the *next* regularly scheduled Board meeting, your appeal will be decided at the *second* regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the *third* regularly scheduled Board meeting following receipt of your appeal. (In such cases, you will be sent a written notice informing you of the date when your appeal will be decided and the special circumstances requiring extension of the time to decide your appeal.)

You will be notified of the decision on your appeal as soon as possible, but no later than *five* days after a decision on your appeal is reached. The notice you receive will contain the information listed in the definition of *Notice of Adverse Decision* on pages 33 and 47.

Authorized Representative. You can act on your own behalf in filing and/or appealing your claim, or you may ask another person to act as your "Authorized Representative." If you designate an Authorized Representative, he or she will receive all communications about your claim or appeal.

Right to Sue

A lawsuit to obtain benefits is considered untimely if filed before you appeal a denied claim, or before the time period for filing an appeal ends, or while your appeal is still pending decision.

The only basis for filing a lawsuit under the federal benefits law called ERISA before the claims and appeals process is complete, is that the Plan failed to conform to the claims and appeals requirements explained on page 32 and pages 33-34.

Claims and Appeals Timetable

The timeline described for filing and appealing claims is summarized in the chart below.

CLAIMS AND APPEALS TIMETABLE

The timeline described above for filing and appealing claims is summarized in the chart below.

Time Limits	TYPE OF CLAIM		
	Urgent Care Claim	Pre-service Claim (non-urgent)	Post-service Claim
To make an initial claim determination	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days
Extension (if proper notice and delay is beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request appeal	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on medical circumstances)	30 days	1st, 2nd or 3rd Board of Trustees meeting after submission

NOTE: Concurrent Care Claims are subject to time deadlines that are sufficient to allow you to appeal before benefits are terminated or reduced.

Right of Reimbursement

The TBT Board of Trustees reserves the right to recover claim payments under any of its Plans made on behalf of a covered person if the Trust overpays a claim. In such cases, the covered person is obligated, as a condition of coverage under the Plan, to reimburse the Trust for the amount overpaid, unless the amount is returned by the provider of services. If claims on behalf of you or your covered spouse have been overpaid by the Trust and you or the provider of services do not repay this amount to the Trust, the Trust may recover the overpayment by a lawsuit or by deducting it from any future benefit payments payable to you or assigned by you.

Coordination of Benefits

If you or your spouse are also covered by another group plan, the benefit payable by this Plan may be reduced. Benefit payments are coordinated between the plans so that you do not receive payment for more than 100% of the Usual, Customary and Reasonable (UCR) medical expenses for the covered treatment. The benefits payable under the Plan will not be greater than the actual amount that would have been paid if there were no other group plan involved.

How Coordination Works. If you are not entitled to Medicare, one of the two or more plans involved is the primary plan and all the other plans are secondary plans. The primary plan pays benefits first—as if there were no other group plans. Then, the secondary plans *coordinate* their payments so that the total payments from all plans are not more than the actual cost of the covered expenses incurred. Coordination does not apply to Medi-Cal benefits.

In the case of hospital charges, the difference between the cost of a private hospital room and the cost of a semi-private hospital room is not a covered expense unless use of a private hospital room is considered medically necessary as generally accepted in health care practice for the condition for which you have been hospitalized.

Order of Payment. If you are not Medicare-entitled, the *first of the following rules to apply* determines which plan pays benefits first:

1. A plan without a coordination of benefits provision or with a provision which bars coordination with this Plan is primary.
2. A plan covering a patient as an employee (rather than as a dependent) is primary.
3. A plan is also *primary* if it covers a patient as an active employee or as the dependent of an active employee, and *secondary* if it covers the patient as a retiree or spouse of a retiree. If you are covered as a dependent under your spouse's active employee plan, then your spouse's plan pays benefits first as the primary plan and this Plan pays second as the secondary plan. Benefits are then coordinated.
4. If a plan covers you as an employee or dependent of an employee and a TBT Plan covers you as a COBRA participant, the plan which covers you as an employee or dependent of an employee pays its benefits first.

When you or your covered spouse become entitled to Medicare, federal guidelines determine the primary and secondary plans. Benefits are then integrated as explained on pages 13-14.

End Stage Renal Disease (ESRD) coordination may differ and is subject to federal guidelines. Contact the TBT Plan Administration Office if you have questions about ESRD coordination issues.

If Other Plan Limits Coordination. If (a) this Plan is secondary and (b) the plan that would be primary under these rules limits or reduces its payment of benefits because of coordination with this Plan, this Plan will pay no more than it would have paid as a secondary payer had the primary plan paid benefits without coordination with this Plan and without regard to such limitation or reduction of benefits because of coordination with this Plan.

Medical Benefit Payments. You should always file your medical expenses with the primary plan *first* so it will start paying benefits immediately. It pays benefits before the secondary plan—just as if it were the only medical coverage.

Once the primary plan pays its maximum benefit, any secondary plans coordinate their benefits under each plan's rules. Each plan will pay its maximum benefit toward the difference—but never more than 100% of the total covered expenses. Each follows its own special rules about using preferred providers, and may have different benefit levels and maximum amounts.

If the primary plan has paid benefits under a PPO Agreement on behalf of a covered person who is not Medicare-entitled, this Plan makes additional payments only if the primary plan requires that you make a copayment. This Plan's payment is limited to your copayment so long as it does not exceed the amount that this Plan would have paid if it were the primary payer. Remember, the PPO provider has agreed to accept contract rates. Therefore, total benefits paid by all plans must not exceed the maximum payment required by the lowest contract rates.

To make sure you receive maximum benefits, it's a good idea to file claims under each plan. Check the details for each plan to see how covered expenses are paid. Contact the TBT Plan Administration Office if you are not sure how amounts are coordinated.

HMO Coordination. If you join an HMO option offered through TBT and your spouse has medical coverage under a group plan, the group plan may not pay benefits if you choose a health care provider or facility that is not associated with that HMO. See the separate disclosure material provided by each HMO for more information.

Coordination with Preferred Network. If your TBT coverage is secondary and your primary plan denies your claim for benefits because you have elected to receive treatment from a provider or facility outside of your primary plan's network, TBT will coordinate benefits as though you received benefits from the primary plan under the primary plan's ordinary level of payment for preferred network hospitals or doctors. For example, if your primary plan pays 90% of covered charges at a preferred provider, and 80% of covered charges at an out-of-network provider and you elect to see an out-of-network provider, TBT will coordinate benefits as though you received services from a preferred network provider and pay no more than 10% of the charges covered by your primary plan.

Coordination of Prescription Drug Payments. Prescription drug coverage through TBT is coordinated with any other group plans so that you receive payment for no more than 100% of covered expenses. The coordination of benefits rules are the same as those for the Indemnity Medical option.

Individual Plan Coordination. If you or your covered spouse (or both) are insured under an *individual* health plan or insurance program for which you pay premiums directly to the insurance company, this Plan pays the full benefits to which you are entitled, regardless of any reimbursement you might receive from any individual policy.

The Plan's Coordination of Benefits rules apply to any *group* insurance coverage or other method of group coverage, which provides medical benefits or services on an insured or uninsured basis. The rules also apply to coverage by any governmental plan (except Medicaid, Title XIX of the Federal Social Security Act, as amended).

The Plan's Coordination of Benefits rules also include any plan that is required by law or by a no-fault vehicle plan to provide medical payments that are made in whole or in part without regard to fault.

In the case of no-fault motor vehicle plans, a person subject to such a law who has not complied with the law is considered to have received the benefits required by the law.

Right to Collect and Receive Needed Information

The Teamsters Benefit Trust reserves the right to provide or obtain any information needed to determine benefits under its Coordination of Benefits provisions, without the consent of any person. If an overpayment is made as the result of a Coordination of Benefits error or for any other reason, TBT reserves the right to recover the amounts overpaid from you or from the benefit plan, insurance company, organization or provider to whom the overpayment was made. If you or your spouse have been overpaid and do not promptly pay back the overpaid amount to the Plan, TBT may recover the overpayment by deducting it from any future benefits payable to you or assigned by you. TBT also reserves the right to make restitution to another plan that has overpaid, and this payment is considered a benefit payment under the Plan made on your behalf.

Right to Recover Benefits

Whenever payments have been made by your TBT Plan with respect to covered expenses where the total amount is greater than the maximum amount needed to satisfy the intent of the *Coordination of Benefits*, the Board of Trustees has the right to recover such payments, to the extent of such excess, from among one or more of the following: Any persons to or for whom such payments were made, any insurance companies, or any other plans or organizations.

If these rules are not followed for a claim, this does not mean the Plan has waived the Board of Trustees' right to invoke these rules for past or future claims.

Based on the specific circumstances particular to how a claim is submitted, the Plan may pay benefits before resolving whether or not such care is actually covered; this does not mean that the Plan exclusions were waived. If it is found that such care is not covered, the Plan may require the covered person or provider of services to repay any overpayment.

Recovering Benefits from a Third Party

The Teamsters Benefit Trust reserves the right to recover claim payments made under any of its Plans on behalf of a participant or covered spouse where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse the Plan in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the Plan for the claims it has paid related in any way to that recovery, the Trust will sue you to recover the amounts paid and/or deduct them from any future benefit claims (even if you have assigned your benefits).

What is a third party and when are they responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his/her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's 'uninsured motorist's' provision is a third party for this purpose.
- If you are injured in an auto accident and covered under a "no fault" provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's Workers' Compensation policy is the third party.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party.

Third Party Liability

The Plan pays claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible, but by submitting the claim for payment by the Plan you (and a covered spouse if he or she suffers the illness or injury) are deemed to agree to each of the following conditions:

1. That the Plan established an equitable lien on any recovery received by you (or your spouse, dependent, legal representative, agent, trustee or trust fund).
2. To notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury.
3. To hold any reimbursement or recovery received by you (or your spouse, dependent, legal representative, agent or trustee) in trust on behalf of TBT to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss.
4. That the Plan has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or covered spouse is made whole) and that the Plan's claim has first priority over all other claims and rights.
5. To reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid.
6. That the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise.
7. That the Plan's claims shall not be reduced under the *doctrine of contributory or comparative negligence.*

8. That, in the event you elect not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your right of recovery and may pursue your claims.
9. To assign, upon the Plan's request, any right or cause of action to the Plan.
10. Not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement.
11. To cooperate in doing what is necessary to help the Plan recover the benefits paid or in pursuing any recovery.
12. To forward any recovery to the Plan within ten days of disbursement by the third party or to notify the Plan as to why you are unable to do so, and
13. To the entry of judgment against you (and, if applicable, your covered spouse, dependent, legal representative, agent, trustee or trust fund), in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorney fees and costs.

If you or your covered spouse have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your covered spouse fail or refuse to assist Plan representatives in recovering damages from a third party, then the Plan may:

- Offset what is paid on your and/or your covered spouse's future benefits claims until the Plan is completely reimbursed for the cost of these claims, including but not limited to costs incurred in collection, and
- File a lawsuit against you, your spouse, dependents, legal representative, agent, trustee or trust fund to fully recover the amount the Plan should have been reimbursed, and/or
- Take any other action deemed appropriate by the TBT Board of Trustees.

If you or your covered spouse do not receive payments from a third party to reimburse the Plan for an illness or injury caused by the third party, you do not have to pay the Plan back for any benefits properly paid to you or your covered spouse. If you do receive payment from the third party, you do not have to pay the Plan more than the amount the third party paid to you or your covered spouse.

If you have questions about how to meet these third party liability rules, contact the TBT Plan Administration Office.

If you recovered from a third party and the Plan has not been reimbursed for claims it paid on your or your spouse's behalf, the Plan reserves the right to offset the cost of claims paid on your third party injury against payment of future benefit claims filed by you or your spouse.

ERISA INFORMATION

This section provides legally required information for your knowledge and protection.

Plan Name

The full name of your Teamsters Benefit Trust Plan is the *Comprehensive Retiree Plan (CRP)* (as listed on the cover of your *Summary of Coverage*). Some participants also may have coverage under supplemental benefit plans as provided by their Collective Bargaining Agreement. If so, these supplemental plans are separately funded and are not part of the benefits explained in this guide. If you are eligible for such benefits, your package should contain information about your supplemental benefit coverage.

Board of Trustees

At the time this guide is printed, there are more Union Trustees than Employer Trustees. However, under the terms of the TBT Trust Agreement, Employer and Union Trustees have equal voting strength regardless of the number of Trustees. The Trustees meet regularly for purposes of administration of the Plans sponsored by TBT.

As of the printing of this booklet, the Trustees are as shown on this page.

Union Trustees

Rome A. Aloise, Co-Chairman
Teamsters Benefit Trust
Secretary-Treasurer
Warehouse, Mail Order, Retail Employees and Wholesale Liquor Salespersons
Teamsters Local Union No. 853
2100 Merced Street, Suite B
San Leandro, CA 94577-3247

Van Beane
Secretary-Treasurer
Brotherhood of Teamsters and Auto Truck Drivers
Teamsters Local Union No. 85
850 Harrison Street
San Francisco, CA 94107-1125

Carlos Borba
President
General Truck Drivers, Warehousemen, Helpers and Automotive Employees
Teamsters Local Union No. 315
445 Nebraska Street
Vallejo, CA 94590-3830

Robert Morales
Secretary-Treasurer
Sanitary Truck Drivers and Helpers
Teamsters Local Union No. 350
295 89th Street, Suite 304
Cedar Hill Office Building
Daly City, CA 94015-1656

Douglas O'Neal
Trustee, Teamsters Benefit Trust
c/o Lipman Insurance Administrators, Inc.
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Ron Paredes
Business Representative
Warehouse, Mail Order, Retail Employees and Wholesale Liquor Salespersons
Teamsters Local Union No. 853
2100 Merced Street, Suite B
San Leandro, CA 94577-3247

Dale Robbins
Secretary-Treasurer
General Truck Drivers, Warehousemen, Helpers and Automotive Employees
Teamsters Local Union No. 315
2727 Alhambra Avenue
P.O. Box 3010
Martinez, CA 94553-8020

Employer Trustees

Keith Fleming, Co-Chairman
Teamsters Benefit Trust
President
IEDA
2200 Powell Street, Suite 1000
Emeryville, CA 94608-1809

William Albanese
President
Central Concrete Supply
755 Stockton Avenue
San Jose, CA 95126

Richard Jordan
Trustee, Teamsters Benefit Trust
c/o Lipman Insurance Administrators, Inc.
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Richard Murphy
Group Controller
United Parcel Service
2574 Barrington Court, Building A
Hayward, CA 94545-1133

Jeanette Paige
Director of Human Resources
Southern Wine & Spirits of Northern California
33321 Dowe Avenue
Union City, CA 94587

Bill Rossi
Trustee, Teamsters Benefit Trust
c/o Lipman Insurance Administrators, Inc.
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Open Seat

Plan Administration

This information applies to all of the Plans explained in this guide, except HMO options offered by TBT. Information about these benefits may be found in separate disclosure material from the providers. Contact the TBT Plan Administration Office if you need these materials.

Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Plan Agent for Service of Legal Process

The Fund Manager listed below is named as the agent on behalf of the Board of Trustees for service of legal process. Legal process may also be served on any member of the Board of Trustees.

Nora Johnson
Fund Manager
Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Employer Identification Number

EIN 94-2848389. The Plan identification number is 501.

Type of Plan

The Comprehensive Retiree Plan described in this guide is a collectively bargained and jointly trusteed health and welfare plan that provides benefits for eligible retirees and their covered spouses.

Plan Funding—Collective Bargaining Agreements

The Plan is primarily funded by monthly contributions from participating retirees. Certain Employers also contribute to the Plan on behalf of their retired employees. In some cases, Employer contributions on behalf of active employees help pay for retiree self-payment contributions as provided by the collective bargaining agreements. You and/or your beneficiaries may receive from the TBT Plan Administration Office, upon written request, information as to whether a particular Employer is a sponsor of the Plan and, if so, the sponsor's address. Your Plan is maintained subject to the collective bargaining agreements providing for Employer contributions to the Plan. A copy of any such agreement may be obtained by you or your beneficiaries upon written request to the TBT Plan Administration Office and is available for examination by you or your beneficiaries at the TBT Plan Administration Office during regular business hours.

Your eligibility for benefits under the Plan depends on the continued receipt of your self-payment contributions. If you stop making self-payment contributions to the Trust, your eligibility for benefits will end in keeping with Plan rules.

Contributions made by participating Employers and self-payments made by retirees are determined by the TBT Board of Trustees under the authority of the provisions set forth in the collective bargaining agreements and Trust Agreement.

Plan Assets

The assets of the Plan are held in trust for the sole purpose of funding TBT benefits and paying the costs of administration of the Trust and its Plans.

Source of Benefits

Hospital and medical benefits are paid for directly by the Trust, unless you have enrolled for hospital and medical benefits with an HMO, in which case TBT pays the HMO monthly premiums and the HMO funds the benefits. Prescription drug benefits are administered by Prescription Solutions and are paid directly by the Trust. The Plan requires Medicare HMO enrollees to use that HMO's pharmacy for prescription drug benefit.

Addresses for the current HMOs and Prescription Solutions are listed on the back cover. Keep in mind that this information may change. Contact the TBT Plan Administration Office if you need help contacting a provider.

The payment of uninsured benefits and the premiums required by the HMOs are payable out of the Trust Fund and are limited to the availability of assets in the Trust Fund that are collected and available for this purpose.

Plan Year

The Plan's 12-month fiscal year for record keeping and accounting purposes ends each September 30.

Effective Date of the Plan

August 1, 1991

Future of the Plan

The Teamsters Benefit Trust and all Plans it sponsors are established and maintained through the collective bargaining process. The Board of Trustees anticipates that the Plan under which you are covered will continue as long as the Collective Bargaining Agreements so provide or until the Trustees decide to end the Plan or the Teamsters Benefit Trust.

However, the Board of Trustees reserves the right to change or discontinue any Plan at any time for any reason without need for prior approval by any person, Employer or Union. Such amendments may change benefit levels, eligibility requirements or any other provision of the Plan.

The Board of Trustees may update the Plan to reflect changes in laws and regulations as well as for other reasons. Any changes to the Plan will not lower amounts already payable for claims incurred before the Plan changes become effective.

Federal law prohibits use of Plan assets for any purpose other than providing Plan benefits and paying the reasonable administrative expenses of the Trust and the Plans it sponsors. If the Plan or Trust ends, the remaining assets will continue to provide Plan benefits until there are no more assets left, or will be used in a way that is consistent with the purpose of the Plan and Trust.

In no event will termination of the Plan and Trust result in the reversion of Trust assets to any Employer.

Authority of the Board of Trustees

The Trust Agreement gives the Board of Trustees the authority to make any determination of fact necessary and proper to the administration of TBT. It also gives the Trustees the power to construe and interpret the rules of the Plan and the Trust Agreement relating to eligibility of covered retirees and their covered spouses to receive benefits. Such decisions are final and binding upon all parties, including those filing any claims.

Assignment of Benefits

Except as authorized by federal law, your benefits under the Plan cannot be assigned and are not subject to garnishment or attachment. (See the Plan's right of reimbursement rules on page 35).

Information about Taxes

The Plans described in this guide provide benefits to eligible retirees and their covered spouses in keeping with federal law and governing documents. It is intended that the value of coverage generally be non-taxable, for federal income tax purposes.

ERISA Rights Statement

As a participant in the Teamsters Benefit Trust Comprehensive Retiree Plan (CRP), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to receive information about your plan and benefits:

Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administration office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. You may continue health care coverage for your eligible spouse if there is a loss of coverage under the plan as a result of a qualifying event. Your spouse may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation of coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Preexisting Conditions. Under your Group Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforcing Your Rights. If your claim for a health and welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them 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 control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person 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.

Assistance with Your Questions. If you have any questions about your plan, you should contact the TBT Plan Administration Office. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the TBT Plan Administration Office, you should 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, Employee Benefits Security Administration, 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 the Employee Benefits Security Administration at (866) 444-3272.

Newborn and Maternity Coverage

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 the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Health Insurance Portability & Accountability Act of 1996

Your Health Information and Privacy. The health benefit options offered under the Plan use Protected Health Information about you and your covered dependents only for the purposes of providing treatment, paying claims and related functions.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective April 14, 2003, the health benefit plan options offered under the Plan comply with the applicable health information privacy requirements in Title II of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the applicable federal regulations issued by the *Department of Health and Human Services*.

Health Insurance Portability. The *Health Insurance Portability and Accountability Act of 1996* requires this Plan to provide you with a certificate of creditable coverage that may help you avoid part or all of a preexisting condition limitation a succeeding group plan may impose. Please call the TBT Plan Administration Office if you have any questions about the certificate of creditable coverage.

Use and Disclosure of Health Information. The Plan may use your health information, that is, information that constitutes protected health information as defined in the *Privacy Rule* of the *Administrative Simplification* provision of the *Health Insurance Portability and Accountability Act of 1996 ("HIPAA")* for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has a policy to guard against unnecessary disclosure of your Protected Health Information.

Here is a summary of the circumstances when your protected health information may be used and disclosed:

To Make or Obtain Payment. The Plan 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 Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Plan may also disclose Protected Health Information over the telephone to your spouse, another family member or a personal representative (such as a Union business agent or Employer representative) for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Plan to speak to this person on your behalf. If you do not wish the Plan to release your Protected Health Information to your spouse, family member or personal representative without prior *written* authorization, please follow the instructions under the *Right to Request Restrictions* found in this notice (see page 45).

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all participants. For example, the Plan may use your health information to conduct case management, quality improvement and utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider that contacts the Plan to verify your eligibility.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities generally include information:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The Plan sponsor represents that adequate separation exists between the Plan and Plan sponsor so that Protected Health Information will be used only for Plan administration. As a jointly trusteed multiemployer trust fund that contracts with a third party administrator, the Plan sponsor has no employees. No person under the control of the Plan sponsor has access to your Protected Health Information. The Plan may disclose your health information to the Plan sponsor for Plan administration functions performed by the Plan sponsor on behalf of the Plan. Such administration shall include, but is not limited to, the following purposes: Appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits and Plan design. The Plan also may provide summary health information to the Plan sponsor so that the Plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

As a condition for obtaining Protected Health Information from the Plan and other insurers and HMOs participating in the Plan, the Plan sponsor agrees to:

- Use or disclose any Protected Health Information received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the Plan sponsor may provide Protected Health Information to agree to the same restrictions and conditions that apply to the Plan sponsor with respect to Protected Health Information.
- Bar the use or disclosure of Protected Health Information for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the Plan sponsor.
- Report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your Protected Health Information available for purposes of your request for inspection or copying.
- Make Protected Health Information available to the Plan to permit you to amend or correct Protected Health Information contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Plan and to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining the Plan's compliance with the Privacy Rule.
- If feasible, return to the Plan or destroy all Protected Health Information received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of Protected Health Information to carry out the functions for which the information is requested.

When Legally Required. The Plan discloses your Protected Health Information when it is required to do so by any federal, state or local law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Conduct Health Oversight Activities. The Plan may disclose your Protected Health Information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your Protected 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.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, 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. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, federal regulations require the Plan 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.

For Worker's Compensation. The Plan may release your health information to the extent necessary to comply with laws related to Worker's Compensation or similar programs.

Authorization to Use or Disclose Health Information. Other than as stated above, the Plan does not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to Your Health Information. You have the following rights regarding your health information that the Plan 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 Plan's disclosure of your Plan Health Information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at the TBT Plan Administration Office.

Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan 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 Officer at the TBT Plan Administration Office. The Plan attempts to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at the TBT Plan Administration Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at the TBT Plan Administration Office. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan'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 Plan 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 Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at the TBT Plan Administration Office. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six years. The Plan provides 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 Plan informs 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 Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the TBT Plan Administration Office.

Duties of the Plan. The Plan is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy Notice and will provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Plan 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 Plan should be made in writing to the Privacy Officer at the TBT Plan Administration Office. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person. The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Officer at:

TBT Plan Administration Office
Privacy Officer
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200
(510) 796-4676 or (800) 533-0119

Effective Date. The Plan's privacy policies and procedures are effective April 14, 2003.

IMPORTANT WORDS

Here is a list of important words used in this guide with specific meanings:

Accident and Accidental Injury. Physical injury resulting from a sudden, violent and external force which was not expected and could not have been reasonably foreseen or avoided.

Adverse Decision. If the Plan denies, reduces, terminates, or fails to provide or make payment (in whole or in part) for a benefit, you are sent a *Notice of Adverse Decision* that includes the following:

- The specific reasons for the adverse decision.
- Reference to the specific Plan provisions on which the adverse decision is based.
- A statement about your rights to bring a civil action under ERISA following an adverse benefit decision on an appeal or the denial of your claim.
- A description of any additional material or information needed to make a full and complete claim, and the reason why it's needed.
- A description of any documents possessed by the TBT Plan Administration Office that are relevant to your appeal (copies available upon request).
- A copy of any internal rule, guideline or protocol that was relied on to decide your claim (or a statement that a copy is available upon request at no charge).
- For adverse decisions based on the absence of medical necessity or the use of experimental or investigational treatment (or any similar reason), an explanation of the scientific or clinical judgment for the determination as applied to the Plan and your claim (or a statement that this explanation is available upon request).
- An explanation of the Plan's appeal procedures and time limits.

Adverse Decision on Appeal. If you appeal an adverse decision, you receive a *Notice of Adverse Decision on Appeal* that contains all information listed in the definition above concerning your appeal (except the appeal procedures and time limits explained on pages 33-34).

Authorized Representative. Someone you designate to act on your own behalf in filing or appealing your claim. If you designate an Authorized Representative, that person is sent all communications about your claim or appeal.

Blue Cross Life and Health. The organization selected by the Teamsters Benefit Trust to administer required procedures such as Pre-admission Certification, Utilization Review and Case Management services (see pages 18-19). *These procedures do not apply to Medicare-entitled participants.*

Blue Cross Prudent Buyer PPO Network. The Indemnity Medical option's Preferred Provider Organization (PPO) for hospitals, doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health providers and other providers. (The Blue Cross PPO network does not apply to HMOs).

Costs for covered services by PPO providers are usually lower than charges for the same services by non-PPO providers. See your Blue Cross Prudent Buyer PPO directory for a list of current providers in the Anthem Blue Cross network. If you need a copy, call the TBT Plan Administration Office. You can also check whether a provider is in the PPO network by calling Blue Cross at (888) 887-3725.

Chiropractic Treatment. Treatment provided, supervised or directed by a licensed chiropractor (including neuromuscular and physical medicine) incurred while under a chiropractor's care, including such care prescribed by a medical doctor and performed by a physical therapist.

Claim. A claim is any request for Plan benefits made in keeping with the Plan's claims filing procedures. Your Plan has several definitions related to different types of claims. See *Claiming Benefits* on pages 30-38.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law lets you and your covered spouse continue benefits coverage under certain circumstances when coverage would otherwise end.

Collective Bargaining Agreement. The written agreement between a participating Employer and a Local Union affiliated with the International Brotherhood of Teamsters (or any other Union approved by the TBT Board of Trustees) that provides for Employer Plan contributions on behalf of certain retirees and was approved by the Board of Trustees.

Convalescent Care Facility. (See *Skilled Nursing or Convalescent Care Facility* on pages 20 and 51.)

Coordination of Benefits. The way many group benefit plans handle payments when there is coverage under more than one plan. Benefit payments are coordinated between the plans so a covered person does not receive more than 100% of the cost of the covered treatment. If you have additional coverage under the Supplemental Retiree Plan (SRP) or the Basic Retiree Plan (BRP), benefits will be coordinated between this Plan and the other TBT Plans. The CRP will be the primary payer, the SRP the secondary payer and the BRP the third payer.

Copayment. A percentage of expenses payable by the participant. For example, when the Indemnity Medical option pays a covered expense at 80% of Usual, Customary and Reasonable charges (UCR), you pay the remaining 20% of UCR (plus any amounts higher than UCR). If you are a Medicare participant, in most cases Medicare is the *primary* source of medical benefits and the Indemnity Medical option is *secondary*. In general, the Indemnity Medical option works together with Medicare to cover a majority of your eligible expenses. For example, when Medicare pays a covered expense at 80% of the Medicare-approved amount, the Plan pays the remaining 20% of the Medicare-approved amount. You pay any amounts higher than the Medicare-approved amount.

If you are covered under a TBT HMO, *copayment* can also mean the amount you pay at the time you receive services through the HMO. After this type of copayment, most covered services are paid in full.

Covered Expenses (under the Indemnity Medical option). An expense for hospital, medical, surgical or prescription drug services or supplies provided by and not subject to any exclusions under the Plan. *For Medicare-entitled participants, any charge that is higher than the Medicare-approved amount is not considered a covered expense.* For participants age 65 or older and not yet Medicare-enrolled, the Plan pays a maximum benefit of 20% on any claim that would otherwise be covered by Medicare.

Covered expenses may be less than the Usual, Customary and Reasonable (UCR) charges for similar treatment as determined by the Plan. Just because an expense is *covered* does not mean it will be paid in *full* by TBT.

Custodial Care. Care that is primarily to assist or maintain the day-to-day activities of a person rather than for treatment of an illness or injury. For example, custodial care may include, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets, or supervising self-administration of medication that does not need constant attention of trained medical staff.

Deductible. The amount that you and your covered spouse pay each calendar year before the Plan begins to pay benefits (see your *Summary of Coverage* for details). The Explanation of Benefits (EOB) explains when deductibles have been met and the amounts to be paid by your TBT medical option.

Doctor. A physician or surgeon (M.D.) licensed to practice medicine in a state where the practice resides, and a podiatrist, chiropractor, doctor of osteopathy (D.O.) or psychologist who provides care or treatment within the limits of the license issued to him or her by the applicable licensing agency of the state where treatment is provided.

Doctor also includes any licensed clinical social worker or licensed and registered physical therapist who, upon referral by a doctor of medicine or doctor of osteopathy, performs services within their license covered by your TBT Plan.

However, if the *doctor* is your spouse, parent, child, brother or sister, benefits are paid only when you provide satisfactory evidence that the covered expenses were actually received and that you paid the doctor for the exact services provided.

Domestic Partner. A Domestic Partner is an individual who meets the conditions and requirements set forth on page 4 of this guide.

Drugs. Any article or medication that can be lawfully dispensed only through a written or oral prescription by a doctor (other than a chiropractor or psychologist) or by a dentist licensed by law to administer it.

Emergency. The sudden, unexpected onset of symptoms or a medical condition that is severe enough to require immediate medical attention and urgent care without which the person's health would be in jeopardy, there would be serious medical consequences, damage to bodily functions, or severe and permanent consequences to any bodily organ or part.

Employer or Participating Employer. An Employer or Employer organization that has a Collective Bargaining Agreement with the International Brotherhood of Teamsters (or any other Union approved by the TBT Board of Trustees) requiring monthly contributions to the Teamsters Benefit Trust.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Experimental Treatment. Any services, supplies, materials or accommodations determined by TBT to be a medical or health care procedure or treatment:

- That are not recognized as conforming to safe and accepted medical or health practice, and
- In which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness established, and
- For which the required approval of a government agency has not been granted at the time when the services are rendered.

Explanation of Benefits (EOB). For the Indemnity Medical option, an EOB is your record of the types of services received, the total charges and the amount payable by TBT. You receive an EOB each time a claim is processed.

Generic Drug. Prescription medication which is equivalent to a brand name drug and meets the same Food and Drug Administration (FDA) standards for purity, strength and safety. When you choose generic drugs (if available), you pay only the copayment amount (if any) for the prescription.

Group Plan. Any plan providing health benefits or services supported fully or partly through employer payments.

Health Maintenance Organization (HMO). A health care organization (such as Kaiser) that covers only services and supplies received from HMO member providers and HMO facilities. Covered services are generally paid in full after required copayments (if any).

Hospice. A health care facility providing special care in support of terminally ill patients (in the last six months of life) and their families which is established and periodically reviewed by an attending doctor and appropriate personnel of a hospice care agency. (If coverage is through an HMO, see definition of hospice in HMO materials.)

Hospital. An institution that is (1) licensed to provide acute care under all applicable state and local laws, (2) registered as a general hospital by the American Hospital Association, (3) accredited by the Joint Commission for the Accreditation of Hospitals, (4) is primarily engaged in facilitating the diagnosis, medical, surgical treatment and cure of ill and injured persons, (5) maintains permanent and full-time facilities for overnight care for five or more resident patients, and (6) operates under the direction of doctors in regular attendance and provides 24-hour nursing services by graduate registered nurses.

Certain other institutions also qualify as hospitals for purposes of your TBT Plan. They include psychiatric, mental health care or tubercular facilities certified by the American Hospital Association. Rest homes, skilled nursing facilities and convalescent homes are not Hospitals.

Indemnity Medical Option. Medical benefits provided by the Plan as described in this guide and your *Summary of Coverage*.

Intensive Care Unit. A unit of a hospital especially designed and staffed to meet the specific needs of critically or seriously ill patients.

Maximum Annual Benefit. Total benefits payable for covered services or procedures for you or your covered spouse during a calendar year.

Maximum Lifetime Benefit. Total benefits payable for covered services or procedures for you or your covered spouse during your lifetimes.

Medically Necessary. Services or supplies covered by your TBT Plan and provided by a doctor which are (1) necessary to effectively diagnose or treat a specific symptom, medical condition, illness or injury, (2) in keeping with the standards of good medical practice, (3) not primarily for the convenience of the patient, doctor or other provider or for comfort or maintenance reasons, and (4) the most appropriate supply or level of service that can be safely provided. When applied to hospitalization, *medically necessary* further means that acute care as a bed patient is required due to the nature of the services or the type of illness, injury or condition when safe and adequate care cannot be received as an outpatient, and provided at the most appropriate and safe level of care for the patient's condition.

Even though a doctor may prescribe a procedure or treatment, your TBT Plan may not consider it medically necessary.

Medi-Cal. The name for the Medical Care for Public Assistance Recipients program under the California Welfare and Institutions Code and related laws, provisions and amendments.

Medicare. The name for the Health Insurance for the Aged program under Title XVIII of the Social Security Act, as amended, including any related laws.

Medicare HMO Plan (also known as a Medicare + Choice Plan). A Health Maintenance Organization plan specifically designed for people enrolled in Medicare. Medicare pays the Medicare HMO Plan a fixed monthly amount for each person who enrolls whether or not that person uses medical services. In exchange for this payment, the HMO provides each person with all the services he or she is entitled to under Medicare plus any extras unique to the Medicare HMO Plan.

Mental Health Disorder. Conditions that affect thinking, perception, mood or behavior. Such conditions are recognized primarily by psychiatric symptoms that appear as distortions of normal thinking or perception, moodiness, sudden or extreme changes in mood, depression or unusual behavior such as depressed behavior, highly agitated or manic behavior, physical manifestations or other mental and nervous disorders.

Any condition meeting this definition is a mental or nervous illness or disorder, no matter what the cause of the condition may be, either physical, mental or organic, or through environmental cause, or any combination. Any condition meeting this definition is included in it regardless of whether it produces physical or only emotional symptoms. All conditions meeting this definition are mental illnesses for purposes of the Plan.

Open Enrollment. Once Plan coverage begins, you may make changes to your TBT medical options once every 12 months. This is your Open Enrollment period. Each time you change your medical option, your new 12-month period begins. See *Open Enrollment—Changing Your Medical Option* on page 8.

Outpatient Surgical Procedures. Surgery ordinarily performed without overnight hospitalization.

Physician. See definition of *Doctor*.

Pharmacist. A person duly licensed to dispense medications prescribed by a doctor in the state.

Plan. A short name for the collectively bargained *health and welfare benefit plan* available to you as a participant in the Teamsters Benefit Trust. Your TBT Plan coverage is explained in this guide, your *Summary of Coverage*, and any subsequent notices of Plan changes in benefits adopted by the TBT Board of Trustees. The name of your TBT Plan is the Comprehensive Retiree Plan (CRP).

Postpartum Hospitalization. Hospitalization immediately following childbirth.

Pre-admission Certification. Approval through the Plan's Pre-admission Certification and Utilization Review Organization representative (Blue Cross Life and Health) of a non-emergency hospitalization or surgery is required *in advance* of admission or treatment and within 72 hours of emergency hospitalization. **Note:** *These procedures do not apply to Medicare-entitled participants.*

Preferred Provider Organization (PPO). Networks or groups of providers that the Indemnity Medical option maintains through the Anthem Blue Cross Prudent Buyer PPO network. (The PPO network does not apply to HMOs.) **Note:** Residents outside of California use the Blue Cross Blue Shield Nationwide PPO Network.

PPO providers have agreed to accept pre-arranged rates for services (see *Blue Cross Prudent Buyer PPO Network* on page 47). They include hospitals, doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health providers and other providers. (**Note:** If you live outside California, contact the TBT Plan Administration Office for details about services in your area.)

Costs for covered services by PPO providers are usually lower than charges for the same services by non-PPO providers. See the Anthem Blue Cross Prudent Buyer directory for a list of current providers in the network. If you need a copy, call the TBT Plan Administration Office.

Prescription Solutions. The organization selected by the TBT Board of Trustees to administer prescription drug benefits.

Preventive Medical Care. Under the Indemnity Medical option, routine physical exams and related x-rays and lab work, flu shots, pap tests, routine mammograms and PSA tests for detection of prostate cancer.

Provider. Doctors, hospitals, laboratories and other facilities providing services and supplies covered by your TBT Plan.

Review Organization. The organization selected by the Teamsters Benefit Trust to administer required procedures such as Pre-admission Certification, Utilization Review and Case Management services (see pages 18-19).

Skilled Nursing or Convalescent Care Facility. A properly licensed institution that meets the definition of an extended care facility under Medicare Title XVIII of the Social Security Act, as amended. It is primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care, and rehabilitation services for injured, disabled or sick persons, provided that each institution is approved by the Plan representative as a skilled nursing or convalescent care facility or is recognized by Medicare as an extended care facility under Title XVIII of the Social Security Act, as amended.

Spouse. The person married to a covered retiree under a legally recognized existing marriage in the state where you live.

TBT Plan Administration Office. The office of the contract administrator appointed by the TBT Board of Trustees:

Lipman Insurance Administrators, Inc.
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200
Local telephone: (510) 796-4676
Toll-free: (800) 533-0119

Third Party. Any payer or organization that may be liable for paying a claim (other than TBT).

Trust Agreement. The Agreement and Declaration of Trust for the Teamsters Benefit Trust.

Trustees. The Union-appointed and Employer-appointed members of the TBT Board of Trustees selected to hold Plan assets and oversee the administration of the Teamsters Benefit Trust and the Plans that it sponsors (according to the Plan documents, insurance contracts and Trust Agreement).

Union. A Local Union associated with the International Brotherhood of Teamsters (or any other Union approved by the TBT Board of Trustees).

Usual, Customary and Reasonable (UCR)—(under the Indemnity Medical option). The determination by your TBT Plan of the amount most practitioners charge for similar treatment of service in the same or comparable area where the medical treatment was provided.

When you use non-PPO providers, Indemnity Medical benefits are based on UCR charges. If your doctor charges more than UCR, you are responsible for paying the difference. In addition, amounts above UCR don't count toward meeting applicable deductibles, copayments or maximums.

Utilization Review. of your treatment by the Plan's Utilization Review Organization representative after treatment has begun. For hospital visits, acute inpatient care must be necessary for the treatment received or the seriousness of the patient's condition. If safe and effective care is available as an outpatient or in an alternative medical setting, the Indemnity Medical option pays for the less expensive treatment. The organization selected by TBT to provide Utilization Review procedures is currently Blue Cross Life and Health. **Note:** *These procedures do not apply to Medicare-entitled participants.*

INDEX

This index is designed to help you locate specific information about common benefit topics. Broader subjects that are discussed in different sections are cross-referenced.

If You Need Help

If you need help understanding your Plan benefits, the Board of Trustees encourages you to call or write the TBT Plan Administration Office.

TBT Plan Administration Office

Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

Local telephone: (510) 796-4676
Toll-free: (800) 533-0119
Internet Web Site: www.tbtfund.org

Language Notice

This guide gives a summary in English of your rights and benefits under the Comprehensive Retiree Plan (CRP). If you need help understanding any part of this guide or the other materials in this package, contact the TBT Plan Administration Office at the address listed on this page. Office hours are from 8:00 a.m. to 5:00 p.m. P.S.T, Monday through Friday (except holidays). Customer service hours are from 8:30 a.m. to 5:00 p.m. P.S.T. Monday through Friday (except holidays).

Noticia en Español

Este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo el Plan de TBT. Si usted tiene dificultad en entender alguna parte de este folleto, o necesita mas información comuniquese con la Oficina de Administracion del Plan TBT a el domicilio localisado abajo en esta pagina. Horas de oficina: 8:00 a.m. a 5:00 p.m. P.S.T., Lunes a Viernes (excepto dias festivos). Horas de Servicio al Cliente: 8:30 a.m. a 5:00 p.m. P.S.T., Lunes a Viernes (excepto dias festivos). El numero de telefono es (510) 796-4676 o (800) 533-0119.

PHONE NUMBERS AND ADDRESSES

Organization	Phone Numbers	Address	Reasons To Call
TBT Plan Administration Office www.tbtfund.org	(510) 796-4676 (800) 533-0119	39420 Liberty Street, #260 Fremont, CA 94538-2200	TBT eligibility, enrollment (including HMOs), marriage status and dependent changes, contributions, Blue Cross ID cards, prescription drug ID cards, Indemnity Medical option claims, life and accidental death & dismemberment claims and other questions.*
Anthem Blue Cross Prudent Buyer PPO Network www.bluecrossca.com	(888) 887-3725 Outside California: (800) 810-2583	21555 Oxnard Street Woodland Hills, CA 91367	Preferred Provider hospitals, PPO Network physicians and other PPO providers.
Blue Cross Life and Health	(800) 274-7767	21555 Oxnard Street Woodland Hills, CA 91367	Hospital Pre-admission Certification and Utilization Review.
Blue Cross Blue Shield National Network (Outside CA) www.bluecares.com	(800) 810-2583	21555 Oxnard Street Woodland Hills, CA 91367	Outside California: Preferred Provider hospitals, PPO network physicians and other PPO providers.*
PacifiCare www.pacificare.com	(800) 624-8822	One Market Place Spear Street Tower, 12th floor San Francisco, CA 94105-1000	HMO benefit questions*; Web site has list of network physicians.
Kaiser Member Services www.kaiserpermanente.org	(800) 464-4000	1800 Harrison, 9th Floor Oakland, CA 94612-2998	HMO benefit questions.*
Medicare Hotline	(800) 633-4227		Contact the Medicare hotline For general information, for address enrollment details and claim filing.
Prescription Solutions www.rxsolutions.com Mail Service Program Specialty Pharmacy	(800) 797-9791 (800) 562-6223 (800) 711-4555	3515 Harbor Boulevard Costa Mesa, CA 92626	Pharmacy and medication questions.* Contact the TBT Plan Administration Office for all other prescription-related matters.
Teamsters Assistance Program (TAP)	(510) 562-3600 (800) 253-TEAM	300 Pendleton Way Oakland, CA 94621-2109	Substance abuse matters including inpatient programs.
Western Conference of Teamsters Pension Trust Fund www.wctpension.org	(650) 570-7300 (800) 845-4162	355 Gellert Blvd., #100 Daly City, CA 94015-2666	All pension matters.

** **Note:** For initial enrollment, you must provide the completed forms to the TBT Plan Administration Office within 30 days of your eligibility date. See the enclosed enrollment materials and **Guide to Your Benefits**. For general enrollment, benefit information, medical and HMO elections and address changes, contact the TBT Plan Administration Office. For changes in marriage status, contact the TBT Plan Administration Office and provide the required forms and certification by the deadlines explained in the enclosed **Guide to Your Benefits**. Any required forms (including HMO change forms) are mailed to you by TBT.*