TEAMSTERS BENEFIT TRUST

GUIDE TO YOUR BENEFITS

PLAN VI

REVISED JANUARY 2008

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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.

ABOUT YOUR TBT PLAN

TBT has different collectively bargained Plans. Which one is yours?

Your Plan name is printed on the ***Summary of Coverage*** *and* ***Comparison of Medical Benefits*** *provided in the same green folder where you found this guide. If you are not sure which TBT Plan is yours, call the TBT Plan Administration Office.*

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*. If you choose medical coverage through the Kaiser HMO, an enrollment and information packet is sent to you containing the HMO's *Evidence of Coverage*. Together, these materials are intended to provide the information you will need to use your TBT Plan (which is also referred to in the rest of this guide as "the Plan" and "your TBT Plan").

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 48-55.

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

Questions?

If you have questions about the Plan or eligibility that are not addressed in this guide or your *Summary of Coverage*, contact:

Teamsters Benefit Trust (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 4:00 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 48 and in your most recent *Summary of Coverage*. The Board of Trustees has *sole authority* to make decisions about the Teamsters Benefit Trust and the Plans that TBT sponsors. No individual Trustee, Union or Employer representative may interpret your 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 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 benefits or employment.

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 Plan address or other data, contact the TBT Plan Administration Office.*

Update Your Records

Have you recently been married, widowed, divorced or had other important changes? Have you added or changed dependents? It is your responsibility to notify the TBT Plan Administration Office in writing within 30 days about changes that affect the eligibility of your spouse or other dependents or when you wish to add a dependent. (See *Change in Family Status* and *Who is Eligible as a Dependent Child?* on page 4.)

Marital Changes. 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) and your spouse's death certificate (if widowed). Contact the TBT Plan Administration Office for a written explanation of the Plan's domestic partner coverage.

Dependent Changes. Provide the names, Social Security numbers and dates of birth for your covered dependents. Send a copy of the birth certificate if the child is added after one year following birth and (if appropriate) the adoption or legal guardianship documents.

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 or other dependents don't live with you, make sure they know that *all TBT mail is sent to your address*.

REMINDER

Coverage is not automatic. If you don't send in the required enrollment forms within 30 days after you and your covered dependents become eligible, the coverage may be delayed —or even denied if you choose the HMO. You may also lose the opportunity to enroll in the TBT medical and dental options of your choice. See ***How to Enroll****, page 6.*

Special Eligibility Provisions

Some TBT Plans have Hour Bank eligibility provisions that affect participation. These provisions are explained in the *Supplement to the Plan VI Summary of Coverage (for Plans with Hour Bank Eligibility)*. Check your Collective Bargaining Agreement for any special eligibility rules or Hour Bank provisions that may affect participation in your TBT Plan.

Plan Participation

To participate in the Plan, you must work for one or more Employers who are obligated under a written agreement to make contributions to the Plan on your behalf. If your Employer stops making contributions to the Plan, you will no longer be eligible for benefits. (See COBRA coverage on pages 10-12 for information about continuation of coverage if you lose eligibility.)

When Your Coverage Begins

Your coverage begins on one of the following dates:

1. *New Participating Employer*

If you work for an Employer when that Employer starts participating in TBT, your coverage begins on the first day of the month after a month in which you work the minimum hours required by your Collective Bargaining Agreement and your Employer makes the required Plan contributions.

Example #1. *Assume your Employer's new Collective Bargaining Agreement provides for participation in the Teamsters Benefit Trust starting in January and requires your Employer to contribute for any employee who worked 80 hours or more in December.*

Because you worked 80 hours or more in December, your coverage begins on January 1—as long as your Employer actually makes the required Plan contributions for January coverage and your enrollment forms have been received by the TBT Plan Administration Office.

2. *Current Participating Employer*

If you start working after your Employer began participating in TBT, your coverage begins on the first day of the month after the third month in a six-month period in which you work the minimum hours required by your Collective Bargaining Agreement and your Employer makes the required Plan contributions for all three months.

Example #2. *Assume you start working in April for an Employer who already participates in TBT. You work the hours required by your Collective Bargaining Agreement in April, July and September. Your Employer must make the required Plan contributions on your behalf for each of those three months. Your coverage begins on October 1—as long as all required enrollment forms are received. (See* ***How to Enroll*** *on page 6.)*

Note: *If you work the minimum required hours three months in a row (in April, May and June), you become eligible for benefits on July 1—as long as the required contributions are paid and the enrollment forms are received by the TBT Plan Administration Office.*

ENROLLMENT IS NOT AUTOMATIC

All required enrollment forms—including the ***TBT Enrollment Form, Medical Option Form, Dental Option Form*** *(and the HMO application if you choose the Kaiser HMO)—must be received by the TBT Plan Administration Office before your medical and dental coverage begins. See* ***How to Enroll*** *on page 6.*

When Dependent Coverage Begins

Coverage begins for your covered dependents at the same time as yours does—as long as the eligibility requirements are met and the TBT Plan Administration Office receives your completed enrollment forms.

You must notify the TBT Plan Administration Office whenever you add or remove a dependent (including a newborn). Evidence of dependent status, such as a birth certification or court order may be required, depending on the circumstances.

Phone or write the TBT Plan Administration Office as soon as possible, *but no later than 30 days after the event, or coverage may be delayed—or even denied if you are enrolled in the Kaiser HMO.* The HMO has specific requirements for adding or removing dependents. (*See the Kaiser enrollment materials for information about enrolling a dependent.*)

Once TBT is notified, all required forms are mailed to you (as explained in *How to Enroll* on page 6).

Remember, coverage does not begin until after the TBT Plan Administration Office receives your completed enrollment forms (and any other required documents) as requested. (See *How to Enroll* on page 6).

Newborn Coverage

An eligible newborn dependent is covered from birth if notice is provided on time. You must notify the TBT Plan Administration Office in writing no later than 30 days after the date of birth or coverage may be delayed—or even denied if you are enrolled in the HMO. (See *How to Enroll* on page 6.)

Domestic Partnership Coverage

Your Plan covers a domestic partner in the same way that it covers a legal spouse. Below is a summary of the Plan's rules regarding domestic partner coverage.

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 on page 3.)

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 not 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 which 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.

In addition, before your domestic partner can begin coverage, your Employer must agree in writing to include the value of your domestic partner's benefits on your W-2 as taxable income and to pay all employer payroll taxes for such amount; or, alternatively, to confirm in writing to TBT that it has determined that your domestic partner's benefits are not federal taxable income and to accept full and sole responsibility for that determination (for more information see *Tax Consequences of Domestic Partner Eligibility*). Upon request, the TBT Plan Administration Office will provide a form for this purpose.

Exception: If your 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.

Application Process For Domestic Partner Coverage

1. An initial application on the form required by the Plan must be submitted to the TBT Plan Administration Office declaring the intent to apply for domestic partner coverage.
2. Within 30 days of the filing of your initial application, you must send the TBT Plan Administration Office a copy of your *California Declaration of Domestic Partnership* and *Certificate of Registration of Domestic Partnership* issued by the California Secretary of State (or its equivalent issued by a municipal authority as explained in the "Exception" above).

Within this 30-day period, you or your Employer must supply a written confirmation that it will include the value of your domestic partner's benefits in your W-2 as taxable income and pay all payroll taxes on such amount; or, alternatively, confirm that your domestic partner's benefits are not taxable income. Upon request, the TBT Plan Administration Office will provide a form to your Employer for this purpose.

Tax Consequences of Domestic Partner Eligibility

Federal tax laws require TBT to determine how much of an Employer's monthly contribution to TBT is related to the coverage of your domestic partner and to report that amount as additional taxable income paid to you, unless you can show that for purposes of your federal income tax returns you have primary responsibility for your domestic partner's living expenses. In other words, if your domestic partner has a job or supports himself or herself through work of his or her own, you will have to pay the employee payroll taxes each quarter on part of the monthly Employer contribution paid on your behalf. This amount will vary from year to year but is likely to be 30%-40% or more of the monthly Employer contribution. For example, if for your TBT Plan the monthly Employer contribution rate is $850, and the "fair market value" of domestic partner coverage was calculated for that year to be 40% of the Employer contribution, you have an additional $340 per month in taxable income. You will be assessed the federal employee payroll taxes on this amount either monthly or quarterly by your Employer. Your Employer will deduct from your wages the employee payroll taxes due on the fair market value of your domestic partner coverage. Your Employer must agree to be responsible for paying its share of the payroll taxes, if any, attributable to the fair market value

of your domestic partner's benefits. If you leave your employment and elect to self-pay for coverage, you must contact the TBT Plan Administration Office to make other arrangements for payment of the payroll taxes related to your domestic partner coverage.

Your Domestic Partner's Eligibility Date

Eligibility for your qualified domestic partner and any eligible children of your domestic partner begins on the first day of the month immediately following your sending the required documentation to the TBT Plan Administration Office.

How to Enroll a Full-Time Student

Eligible dependent children include your unmarried children under age 19 (or under age 26 if a full-time student based on Plan rules) and who are primarily dependent on you for financial support.

If your covered dependent is a full-time student living away from home, the student's full-time status must be verified each semester (as soon as the student enrolls in classes) or coverage will automatically end (explained on pages 5-6). You are required to provide continued evidence of the student's full-time enrollment prior to the start of each semester to continue this coverage as a full-time student.

You may order an additional prescription drug ID card for a full-time student who lives away from home by calling the TBT Plan Administration Office.

Change in Family Status

It is your responsibility to notify the TBT Plan Administration Office in writing within 30 days when a change occurs that affects the eligibility of your dependents (including your covered spouse) or when you wish to add or remove a dependent.

You must *notify* the TBT Plan Administration Office within 30 days if:

1. You get married or divorced.
2. You establish a domestic partnership.
3. You have a newborn child.
4. You adopt or become the legal guardian of a child.
5. Due to marriage, you acquire stepchildren that you want to cover as dependent children.
6. Your covered child loses coverage due to age (see next column).
7. Your child from ages 19 to 26 changes full-time student status (explained below) or is no longer dependent on you for financial support.
8. A covered family member dies.

With your notice, send a copy of your:

- Marriage certificate
- Certification of domestic partnership
- Divorce decree
- Birth certificate (if a child is added after one year following birth)
- Adoption or legal guardianship documents (see note below)

…to the TBT Plan Administration Office.

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

Note: Evidence of a child's dependent status (including a court order of adoption or an order appointing you as the child's legal guardian) is required. (See above.)

WHO IS ELIGIBLE AS A DEPENDENT CHILD?

*Dependents eligible for coverage (once **you** are eligible) include your lawful spouse, lawful domestic partner and unmarried children defined as follows:*

Children:** Your unmarried sons and daughters (including stepchildren, legally adopted children, or children for whom you and/or your spouse are the legally appointed guardian or the children of your domestic partner) who depend primarily on you for financial support and who live with you for more than six months out of each year, or a person for whom you are required to provide dependent health coverage as the result of a Qualified Medical Child Support Order or QMCSO (defined on page 60). **Note: Children who are eligible as employees in TBT or another group health plan or in full-time service in the armed forces are not eligible as your dependents.

Your eligible children qualify for dependent coverage at the following ages:

1. ***Children** to age 19.*
2. ***Children** ages 19 to 26 provided they are primarily dependent on you for financial support and enrolled as full-time students at an accredited school or college (for at least nine units). **Note: Full-time student status must be verified each semester or coverage will end (explained on page 5).***
3. ***Children** age 19 and over who cannot earn a living due to a mental or physical disability that existed prior to reaching age 19 are eligible provided that proof of disability (in the form of a doctor's written statement of disability) is provided to the Plan upon request (no more frequently than once per year). Coverage ends on the date when the person no longer qualifies for this extension or on the 31st day after failing to provide proof of continued disability as requested.*

COVERAGE IS NOT AUTOMATIC

All changes in dependent status must be made in writing through the TBT Plan Administration Office, even if you have HMO coverage. (See ***Change in Family Status*** *and* ***Who is Eligible as a Dependent Child*** *on page 4.)*

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

How Coverage Continues

Once coverage begins, you and your covered dependents continue to be eligible for benefits as long as you work the required number of hours and your Employer makes monthly contributions on your behalf.

Note: If you belong to a Plan with Hour Bank eligibility, see the separate pages provided inside your *Summary of Coverage* for provisions that affect your Plan participation.

Your eligibility for benefits in any month depends on your Employer's contributions being received in a timely manner by TBT (see *When Coverage Ends* on page 8).

Full-Time Students—How Coverage Continues

Eligible children ages 19 to 26 who are primarily dependent on you for financial support and are enrolled as full-time students at an accredited school or college (for at least nine units) may continue dependent coverage as long as all required documentation is provided to the TBT Plan Administration Office on time (as explained in this section).

Full-time student status must be verified each semester or dependent coverage will end. Certification of enrollment (for nine units or more) must be provided to the TBT Plan Administration Office *prior to the start of each semester* within the following time periods:

1. *Regular Time Periods*

For purposes of eligibility based on student status, TBT divides the year into two *time periods*. For full-year eligibility, the student must satisfy both the Fall and Spring time periods:

- *Fall Eligibility:* Full-time students with verified enrollment for the Fall semester (or quarter) are eligible for coverage through the end of February (October 1 through February 28 or 29).
- *Spring Eligibility:* Full-time students with verified enrollment for the Spring semester (or quarter) are eligible for coverage through the end of September (March 1 through September 30).

2. *Early Enrollment*

For early Fall or Spring enrollment (before the above dates), student eligibility begins the first day of the month when classes start (subject to receipt by the TBT Plan Administration Office of certified full-time student status).

3. *Transition from High School*

Students who graduate from high school after age 19 remain eligible until they graduate (subject to receipt by the TBT Plan Administration Office of certified full-time student status after they reach age 19).

4. *Dropouts*

Dependent coverage ends for students ages 19 to 26 who drop out of school (or fail to maintain their full-time student status) before the end of the term (quarter or semester)—unless student status ends due to disability (explained below). Student dependent coverage ends no later than the last day of the month when the student leaves school or no longer attends full-time (less than nine units). If timely notice is not provided to the TBT Plan Administration Office, coverage ends retroactively.

5. *Disabled Students*

Students ages 19-26 who drop out due to total disability qualify for continued eligibility for up to two time periods beyond the time period in which the disability occurs. *However, the student must be fully qualified under Plan rules when the disability occurs. Certification of full-time student status and a Proof of Disability Claim Form are required.*

Example (see chart below): Assume a student enrolls in the 2008 Spring semester for nine units or more and is actually attending school when dropping out due to disability. Subject to confirmation by the TBT Plan Administration Office of continued disability, student eligibility continues through September 2009 (or when the student reaches age 26 if earlier).

Example	*Time Range*
Time period when disability occurs	*March 1, 2008 - September 30, 2008*
First full-time period	*October 1, 2008 - February 28, 2009*
Second full-time period	*March 1, 2009 - September 30, 2009*

Note: *Proof of disability is required for each time period.*

If Disability Ends Early

If the disability ends before the maximum eligibility period is reached and the student does not return to full-time school, eligibility continues through the end of the time period when the disability ends.

COBRA Continuation Coverage

Loss of eligibility at the end of the second time period (or sooner) is a COBRA qualifying event. See pages 10-12 for information about COBRA.

6. *Correspondence or Trade School Courses*

Correspondence courses are accepted as long as the student is enrolled in the equivalent of nine or more units (at a traditional on-campus educational facility). Study at trade or vocational schools is also accepted with the same unit equivalency requirements. In all cases, the educational institution must be accredited.

How to Enroll

Once you are eligible for benefits, you must enroll within 30 days to have the medical and dental options you want. Future changes in your options can be made once every 12 months. See *Open Enrollment—Changing Your Medical or Dental Option* on page 8).

You enroll yourself and your eligible dependents by completing the following forms (provided in the *Enrollments Materials* folder):

1. ***TBT Enrollment Form.*** The process of starting your benefits won't begin until this form is received (see *Why Enroll?* in the next column).
2. ***Medical Option Form.*** Use this form to choose your TBT medical option (which *must be the same* for you and your covered dependents).
3. ***Dental Option Form.*** Use this form to choose your TBT dental option (which *must be the same* for you and your covered dependents). If you are a newly hired employee, restrictions may apply (see the *Dental Option Form* in the *Enrollment Materials* folder).
4. ***HMO Application.*** The Kaiser HMO application is required for either new or continued Kaiser coverage (see *How to Apply for HMO Coverage* on page 7). *If you need the Kaiser HMO packet and application, contact the TBT Plan Administration Office.* (See Indemnity Medical Option or Health Maintenance Organization [HMO] Option on page 7). Kaiser HMO coverage must be the same for you and your covered dependents.

Why Enroll?

There are important reasons why you should not delay sending in your *TBT Enrollment Form*, *Medical Option Form*, *Dental Option Form* and the Kaiser HMO application (if you choose the HMO).

- Coverage is not automatic. If you don't enroll within 30 days after you first become eligible, you lose the opportunity to enroll in the TBT medical and dental options of your choice.
- Claims are not paid until all required and completed enrollment forms are on file with the TBT Plan Administration Office.
- If you do not select a TBT medical option, you are automatically enrolled in the Indemnity Medical option; however, no claims are paid until your *TBT Enrollment Form* and *Medical Option Form* are on file with the TBT Plan Administration Office.
- If you want medical coverage under the Kaiser HMO, you cannot be enrolled until the TBT Plan Administration Office receives your *TBT Enrollment Form* and *Medical Option Form* plus your Kaiser HMO application. **Note:** *The Kaiser HMO does not accept applications with an effective date more than 60 days before receipt of the Kaiser HMO application.*
- Your prescription drug ID card is not ordered for you until a *TBT Enrollment Form* is received.

Important: *Your prescription drug ID card is mailed to you after the TBT Plan Administration Office receives your* ***TBT Enrollment Form****. 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* Reimbursement Procedures *on page 26).*

- You have no dental coverage until you send in the *Dental Option Form*.
- You won't receive important notices about your benefits because the Plan does not have your mailing address.
- You won't have named a beneficiary to receive Plan benefits if you die or are seriously injured. (You designate your beneficiary on your *TBT Enrollment Form*.)
- You and your covered dependents may face delays when you need to use your benefits.
- Benefit providers cannot verify your coverage.

Contact the TBT Plan Administration Office if you need more enrollment forms.

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 14-23 of this guide or other coverage under the Health Maintenance Organization (HMO) offered through TBT (currently the Kaiser HMO).

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

How to Apply for HMO Coverage

If you want coverage under Kaiser—the TBT HMO option—when you are newly eligible, send your:

- *TBT Enrollment Form*
- *Medical Option Form*
- *Kaiser HMO Application*

…*directly* to the TBT Plan Administration Office for processing. **Do not send the forms to the Kaiser HMO or coverage may be delayed.** Check your *Summary of Coverage* and Kaiser *Evidence of Coverage* for the most current information about Kaiser HMO option.

The Kaiser *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.

IMPORTANT

*All enrollment forms (including the required Kaiser application if you choose the Kaiser HMO option) 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

Kaiser HMO participation *only* applies to medical coverage. Other TBT benefits (such as vision, dental and other benefits described in your *Summary of Coverage*) are not affected by which TBT medical option you choose.

Exception: *Your Plan requires that participants who enroll in the Kaiser HMO use only Kaiser facility pharmacies (except for an eligible out-of-area emergency). Outpatient prescription drug benefits are only provided by the Kaiser HMO facility or mail service (after a copayment per prescription or refill)—rather than through the TBT Indemnity Medical option prescription drug benefits. See the* Comparison of Medical Benefits *and the separate Kaiser material including the* Evidence of Coverage and Disclosure *form.*

Kaiser HMO participants may be eligible for certain alcohol or chemical dependency treatment under the Indemnity Medical option (see pages 20-21 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 Kaiser HMO participants.

Any emergency treatment would only be covered as provided by the Kaiser HMO (see the Kaiser HMO *Evidence of Coverage* for details).

Dental Options

For information about the dental options available through TBT, see:

- *Dental Options* and *If You are a Newly Hired Employee (with a Currently Participating Employer)* on page 28.
- *About the Prepaid Dental Options* on page 33.
- Your *Comparison of Dental Benefits*.

NOT ALL COVERAGE IS THE SAME

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

- *The main difference is that HMOs limit you to HMO providers. If you choose the Kaiser HMO option and go to a hospital, doctor or health care provider that is **not** in the Kaiser HMO, your claims are **not** covered by the HMO (unless the claim involves an emergency as defined by the Kaiser HMO).*
- *If you choose the Kaiser HMO, medical benefits are payable through the HMO (not the Indemnity Medical option) except as specifically noted in this guide or your **Summary of Coverage**. Packets explaining the Kaiser HMO coverage, service areas, claims appeal and denial procedures, enrollment applications and forms are available (at no charge) through the TBT Plan Administration Office.*
- *Kaiser HMO participants must contact the HMO directly about benefit questions and claims appeals. Telephone numbers are listed on page 65. Note that the HMO offered may change.*

Open Enrollment—Changing Your Medical or Dental Option

You may make changes to your TBT medical and dental options once a year.

TBT's Open Enrollment takes place from January 1 through December 31.

After your initial election of medical and dental options, you may make changes to your medical and dental options once every 12 months. Each time you change an option, a new 12-month period begins. You and your eligible dependents must be covered under the same medical and dental options.

Note: You will not be sent medical and/or dental option change forms unless you request them. 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(s).
2. Submit the *Medical/Dental Option Information Order Form* indicating the medical, dental or Kaiser 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* and/or *Dental Option Change Form* to the TBT Plan Administration Office. **Note:** If changing to the Kaiser HMO, a Kaiser application is also required and will be sent to you with the material you requested.

Effective Date of Open Enrollment Changes: Open Enrollment change requests submitted on the required medical and/or dental change forms 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 or dental 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 and/or dental change forms. However, you may phone the TBT Plan Administration Office to:

- Request information on the available medical and/or dental options.
- Request HMO (medical) or DMO (dental) benefit and enrollment material.
- Request medical or dental 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 and dental 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 to the Indemnity Medical option when you move out of the Kaiser HMO service area. You may also change your dental plan option when you move out of the service area for the dental plan option you selected.

Important Note: You and your eligible dependents must be covered under the same medical and dental options. Contact the TBT Plan Administration Office with questions.

IMPORTANT
Other changes outside the annual Open Enrollment are considered upon written request sent to the TBT Plan Administration Office.

Note: If you belong to a Plan with Hour Bank eligibility, see the enclosed pages in your *Summary of Coverage* for details (such as how coverage begins, continues and ends, reinstatement of eligibility and extension of benefits while totally disabled). Contact the TBT Plan Administration Office with questions about Hour Bank eligibility provisions.

When Coverage Ends

Coverage for you and your covered dependents ends on:

1. The first day of a month for which your Employer does not send the required contribution to the TBT Plan Administration Office on your behalf.
2. The first day of a month for which a required self-payment is not received by the 30th day of the same month.

3. The date when you enter full-time military service.
4. The date when you are no longer eligible for benefits.
5. For specific benefits, the date when the covered maximum benefit is reached for that covered participant or when a specific benefit is discontinued.
6. The date when your TBT Plan or participation ends.

Coverage for your dependents ends at the same time yours ends, or *sooner*:

1. For your spouse, when you divorce (on the first day of the month after your divorce is final).
2. For your dependent child, the first day of the month after no longer qualifying as an eligible dependent as defined by the Plan (see pages 2-4).

Reinstatement of Eligibility

If you lose eligibility and return to work with a participating Employer within 12 months, your new eligibility date will be the first day of the month immediately following a month in which you work the hours required under your Collective Bargaining Agreement *and* your Employer makes the required contribution to the Plan on your behalf. If you do not return to work with a participating Employer within 12 months, you are subject to the eligibility requirements for new employees (see page 2). **Note:** If your TBT Plan has Hour Bank eligibility, see the special provisions about Reinstatement of Eligibility explained in the Supplement to the Plan VI *Summary of Coverage* (for Plans with Hour Bank Eligibility).

Note: *If you (1) are enrolled in the Kaiser HMO; (2) experience a lapse in your coverage of six months or longer and (3) then resume working enough to qualify for coverage and (4) want to re-enroll in the Kaiser HMO, you must send a new HMO application to the TBT Plan Administration Office.*

Extension of Benefits While Totally Disabled

If you are eligible but rendered unable to work because you become *totally disabled* as a result of an illness or injury (see the definition of total disability on page 10), coverage for you and your covered dependents will continue for up to three months. If after these three months you remain totally disabled, your Collective Bargaining Agreement may require your Employer to make contributions on your behalf for an additional period. If you remain totally disabled after the first three months and after any Employer-paid extension period, you may further extend your coverage as follows:

1. Self-pay for up to six months for full coverage (medical, prescription drug, dental, vision and life insurance) at the Employer contribution rate.
2. Self-pay for up to 18 months (and, if you remain totally disabled, up to 29 months) for COBRA benefits (except if you become eligible for Medicare) at the COBRA rate then in effect (see *COBRA Coverage* beginning on the next page).

If you choose the six-month option, you may elect COBRA for the balance of the COBRA eligibility months remaining. However, if you experience a second disabling condition during your extended coverage, you are *not* entitled to a further extension.

If you are enrolled in the Indemnity Medical option (rather than the Kaiser HMO option) and you or a covered dependent remain totally disabled at the end of the Plan's three-month extension of coverage and of any Employer-paid extension, (and you do not elect COBRA continuation coverage), *coverage for the disabling condition only* will be continued without self-payment for up to 12 months. However, benefits end as of the earliest date below:

1. The date when the total disability ends.
2. The date when coverage becomes effective without limitation as to the disabling condition under any other medical benefit or service plan written on a group basis or under any group insurance policy.
3. The end of the 12-month period following the date when the Employer contributions paid on account of the eligible person stopped.

Proof of disability must be filed with the TBT Plan Administration Office as soon as possible after you become totally disabled. You can request a *Proof of Disability Claim Form* from the TBT Plan Administration Office. You and your doctor each fill out a portion of the form. Send the completed form to the TBT Plan Administration Office.

HEALTH INSURANCE PORTABILITY

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

WHAT IS TOTAL DISABILITY?

A physical or mental condition for which you need a doctor's care and which prevents you from performing your regular duties as an employee or any employment for wages or profit, or prevents your covered dependent from doing the regular and customary activities for a person of the same age.

For You: *The term means all periods of disability from the same condition. If you recover from this condition and* ***return to active work*** *that is covered by your TBT Plan for a period of at least two weeks, any later period of disability, even from the same cause, is considered a new disability.*

For Your Covered Dependent: *The term means all periods of disability from the same condition. If your dependent recovers and can resume the normal activities of a person in good health of the same age for a period of six months or longer, any later period of disability, even if it results from the same condition, is considered a new disability.*

Disabilities caused by self-inflicted injuries, related to commission of a felony or due to injury or illness related to military service, do not qualify as total disabilities.

COBRA Coverage

The *Consolidated Omnibus Budget Reconciliation Act (COBRA)*, is a federal law that requires group health plans to offer continued coverage by self-payment in certain circumstances after coverage would otherwise end.

When your Employer-paid coverage ends, you and your eligible dependents may be able to continue coverage under the Plan for ***up to 18, 29 or 36 months*** by self-payment.

You and your eligible dependents may choose to continue coverage by self-payment for ***up to 18 months*** if your Employer-paid coverage ends as a result of one of the following ***qualifying events***:

1. Your employment terminates as a result of resignation, layoff, firing or retirement.
2. Your hours are reduced to *fewer* than those required for coverage under your Collective Bargaining Agreement.

If you or your covered dependent is disabled on the date of your initial COBRA qualifying event or becomes disabled (as that term is defined by Title II or XVI of the federal Social Security Act) at any time during the first 60 days after the COBRA *qualifying event*, coverage may be continued for ***up to 29 months***. To qualify for this added COBRA period, you must notify the TBT Plan Administration Office within 60 days of the disability determination from Social Security and no later than the end of your first 18 months of COBRA coverage. If you or your dependents fail to provide notice of the disability determination within 60 days, you and your dependents will forfeit the right to the 11-month disability extension.

The extra 11 months of COBRA coverage for Social Security disability will require a higher monthly self-payment. Contact the TBT Plan Administration Office for the current notification forms and details.

Your Employer is required to inform the TBT Plan Administration Office in the event of a COBRA qualifying event such as an employee's death, termination or reduction in hours.

If, after receiving a notice relating to a qualifying event, second qualifying event or a determination of disability by the Social Security Administration, TBT determines that there is no entitlement to COBRA coverage or extended COBRA coverage, the TBT Plan Administration Office will provide the person 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.

If you decide to continue coverage under COBRA, you will be offered the same coverage that is available to active employees, except that COBRA benefits do not include life insurance (or any weekly disability coverage that may be described in your *Summary of Coverage*).

If you are covered by a regional plan (like the Kaiser 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 18, 29 or 36 months of COBRA coverage.

Your dependents may continue coverage under the Plan for up to a total of 36 months if their Employer-paid coverage ends due to any of the following qualifying events:

1. Your death.
2. Your divorce.
3. Your dependent child no longer qualifies as an eligible dependent as defined by the Plan (for example, the child reaches age 19).
4. You become entitled to Medicare benefits.

If you become entitled to Medicare benefits and, within less than 18 months of the date of Medicare entitlement, terminate employment or experience a reduction in hours which results in the loss of Employer-paid coverage, your dependents will be entitled to COBRA coverage for not more than 36 months beginning with the date of your Medicare entitlement.

Important: *If any of these qualifying events occurs, you or your covered dependent must notify the TBT Plan Administration Office within 60 days of the event. Failure to so notify TBT terminates COBRA rights. The words "covered dependent" for purposes of COBRA coverage include children born to you or placed with you for adoption during the period of COBRA coverage, or a spouse if you are married during the COBRA period. You must notify the TBT Plan Administration Office within 30 days of the birth, adoption or marriage for the dependent to have status as a covered dependent for purposes of COBRA.*

You have ***a maximum of 60 days*** to elect COBRA coverage. 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 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.
2. The date the qualified beneficiary is sent notice of his or her right to elect COBRA coverage.

Family and Medical Leave Act

A leave of absence which qualifies for leave under the *Family Medical Leave Act* (FMLA) or the *California Family Rights Act of 1991* (CFRA) does not constitute a COBRA qualifying event because the Employer remains obligated to contribute to the Plan on your behalf during the leave of absence (see page 13). Under such circumstances, benefits will continue automatically. However, if you don't return from an FMLA or CFRA leave, your Employer-paid coverage will end, at which time you will be offered the option of continuing your coverage under COBRA.

COBRA Payments

You or your dependent 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 Employer-paid coverage ends.*

Under COBRA, you pay the full cost of coverage plus a 2% administration fee—in other words, you pay 102% of the cost of continuing your coverage.

You may elect one of two levels of benefits under COBRA coverage:

1. Medical coverage (including HMO coverage), prescription drug, alcohol or chemical dependency rehabilitation benefits. This is called *core* coverage.
2. The coverage described above plus vision and dental coverage. This is called *core plus non-core* coverage.

Once COBRA benefits are elected, they may not be changed from ***core coverage*** to ***core plus non-core coverage***. However, a one-time change from ***core plus non-core coverage*** to ***core coverage*** is allowed; but you must send a written request to the TBT Plan Administration Office.

If the COBRA period is ***extended to 29 months*** due to Social Security disability, you must pay 150% of the cost for months 19 through 29 of COBRA coverage.

Your first self-payment is due within 45 days of the date you elect to continue coverage. Subsequent payments are due on the first of the month and are delinquent if not received by the 30th day of the month.

If you elect COBRA, the COBRA option you have chosen and the monthly premium you pay will cover you and your eligible dependents. If you elect not to continue coverage by COBRA, your dependents may elect to do so by making the COBRA election and self-payment.

If you or your dependent send a timely monthly contribution that is significantly less than the actual payment due, COBRA coverage is terminated immediately. If you or your dependent send a payment that is not significantly less than the actual COBRA payment due for the month, the TBT Plan Administration Office may notify you or your dependent of the shortfall and require that it is 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.

If you lost coverage under the Plan because your employer shut down its plant because of a shift of production to another country or because of an increase in imports, you may be eligible for a tax credit for your COBRA payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government.

If you become eligible to receive trade adjustment assistance within six months of losing coverage, you may also be entitled to a second COBRA election period if you provide the TBT Plan Administration Office with a copy of the certificate issued to you by a state workforce agency entitling you to federal trade adjustment assistance. The TBT Plan Administration Office will provide you with a COBRA election notice. Your election to continue coverage must be made during the 60-day period that begins on the first day you become eligible for trade adjustment assistance, but no later than six months after you lost your coverage. If you elect COBRA during this period, coverage begins on the first day of the second election period. Your COBRA period, however, is measured from the date you lost coverage. The second election period does not extend the COBRA period available to you.

If you have questions about these new tax provisions, call the Health Care Tax Credit Customer Contact Center toll-free at (866) 628-4282. **Note:** TTD/TTY toll-free number is (866) 626-4282. More information about the Trade Act is available at: www.doleta.gov/tradeact/.

When COBRA Coverage Ends

The COBRA period (which started when you and/or your dependents experienced one of the *qualifying events* described in this section) ends on the earliest of:

1. The end of the 18-, 29- or 36-month period described in this section.
2. The first day of the month in which your payment is not received within 30 days of the due date.
3. The date when you or your dependents become covered under another group plan unless the new group plan contains any exclusions or limitations for pre-existing conditions that directly affect your or your dependents' coverage. This date is not always the same for different members of the same family. At the end of any such exclusion or limitation, COBRA eligibility under TBT will end.
4. The date you or your dependents become eligible for Medicare.
5. The first day of the second month following the date the covered beneficiary, who is subject to the 11 additional COBRA months for the disabled, is determined to be no longer disabled under *Title II* or *Title XVI of the Social Security Act*.
6. The date the Plan ends.
7. The date when your Employer stops providing Plan benefits to any employee.
8. The date determined by TBT that your coverage will end due to any fraud or misrepresentation or because you 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 dependent. The Trust reserves the right to cancel coverage back to the effective date of coverage.

If COBRA coverage ends prior to the 18-, 29- or 36-month coverage period, the TBT Plan Administration Office provides a notice to the affected persons as soon as possible after the determination to end COBRA coverage. The notice explains the reason for the early termination, the date of termination and the availability of alternative group or individual coverage, if any.

If you are enrolled in the Kaiser HMO and your COBRA coverage period is less than 36 months, California law requires that the HMO provide an additional period of continuation coverage, up to 36 months from the date your COBRA coverage began. This additional coverage only applies if you are enrolled in the HMO when you experience a qualifying event. Contact the Kaiser HMO for more information.

If at the end of your COBRA continuation of coverage period you are enrolled in the Kaiser HMO, you may enroll in an individual conversion plan offered by the HMO. This option may cost more and provide fewer benefits than the group health coverage.

Retirees and their eligible dependents have COBRA rights if the Employer from which you retired declares bankruptcy. Contact the TBT Plan Administration Office for more information.

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.

IMPORTANT

*The TBT Plan Administration Office mails your COBRA notice to the home address provided on your **TBT Enrollment Form**. You must notify the TBT Plan Administration Office whenever you or your dependents change your address.*

Family and Medical Leave

You may be eligible for up to 12 weeks of unpaid leave of absence under the federal *Family Medical Leave Act* (FMLA) to take care of family needs such as the birth and care of a newborn, newly adopted child or child placed for foster care, the care of an ill parent, child or spouse, or your own serious health condition that makes you unable to perform your job. You are eligible for an FMLA leave if you have been employed for at least 12 months at a worksite where your Employer has at least 50 employees (or a total of 50 employees within 75 miles of your worksite) and you have worked at least 1,250 hours during a 12-month period immediately before the start of your leave of absence.

If you qualify for leave under the FMLA, your Employer-paid TBT benefits continue until the earliest of the following dates:

1. The date when the leave period granted under FMLA ends.
2. The date when you inform your Employer that you are not returning to work.
3. The date when you do not return to work.

At the end of the FMLA leave, you may be eligible for COBRA continuation of coverage for up to 18 months.

For more information about the FMLA, contact your Employer.

Leave for Military Service

If you go on leave from your covered employment, either voluntarily or involuntarily for active duty or training, Employer-paid coverage continues if your leave is 31 days or less. If your leave continues more than 31 days, you can continue coverage under the *Uniformed Services Employment and Reemployment Rights Act* (USERRA) by paying the USERRA self-pay rate (the same rate for either COBRA core or core plus non-core coverage described on pages 10-12).

Coverage ends on the *earlier* of:

1. The 24-month period beginning on the date your leave started.
2. The day after the date your leave ends and you have not applied for or returned to employment, whichever occurs first.

If your coverage ends due to service in the uniformed services, an exclusion or waiting period may not be imposed during the reinstatement of your coverage when you return to work. However, this requirement does not apply to the coverage of any illness or injury determined by the Secretary of Veteran Affairs to occur or be aggravated during, performance of service in the uniformed services. Regardless of whether or not you elect to self-pay for extended coverage, your coverage will be reinstated immediately when you return to employment immediately following your leave and your Employer will be charged for the cost of your coverage even though you did not work the prior month.

You must elect this coverage; it is not automatic. If you do not give advance notice of your military leave, you will not be eligible to elect USERRA coverage unless your failure to provide such notice is excused under USERRA because it was impossible, unreasonable, or precluded by military necessity, in which case your coverage will be restored retroactively upon payment of all unpaid amounts due. If you give advance notice of your leave, you may elect USERRA coverage at any time within the first 60 days after your last day of employment.

Your first self-payment for USERRA coverage is due within 45 days of the date of your election, and must be retroactive to the date your Employer-paid coverage ends. Subsequent payments are due on the first of the month and are delinquent if not received by the 30th day of the month. If your payment is significantly less than the actual payment due (as described under *COBRA Payments* on page 11) your coverage will end immediately. You may elect either *core* or *core plus non-core* coverage.

Note: Some TBT Plans have special provisions for Hour Bank eligibility—explained in the enclosed pages called *Supplement to the Plan VI Summary of Coverage (for Plans with Hour Bank Eligibility)*. Check your Collective Bargaining Agreement for details about Hour Bank provisions that may affect your coverage.

The duration of the leave combined with all your previous periods of military leave under the same Employer must not be more than five years (unless extended by national emergency or similar circumstance). If USERRA leave ends, you may be able to continue benefits as described under COBRA above. However, your eligibility to self pay under USERRA will run concurrently with any COBRA self-pay period which begins on or after your military leave begins. For more information on USERRA rights, contact your Employer.

If You Have Eligibility Questions

Call the TBT Plan Administration Office with your questions. When calling, refer to your Plan name or number printed on the cover of your *Summary of Coverage*.

IMPORTANT

Only the TBT Plan Administration Office can verify eligibility. Statements or documents about eligibility or coverage provided by other sources, such as your Employer or Union, are not binding on TBT.

YOUR TBT MEDICAL OPTIONS

You may choose one of the medical plan options shown on your *Medical Option Form*. The options include the Indemnity Medical option or the Kaiser Health Maintenance Organization (HMO) 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 Blue Cross PPO network. You can also consult your *Summary of Coverage* for details about 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 the HMO offered by TBT, these benefits are explained in separate materials from the Kaiser HMO. For details on the Kaiser HMO, refer to your Plan's *Summary of Coverage* and *Comparison of Medical Benefits* 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 Kaiser 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.)

The Kaiser HMO's health plan physician must determine that the services and supplies are *medically necessary* to prevent, diagnose or treat your medical condition.

If you are enrolled in the Kaiser HMO health plan, 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*.

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

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 Plan name, calendar year deductible, copayment percentages, special benefits and maximum amounts.

If you have coverage through the HMO offered by TBT, these benefits are explained in separate materials provided by the Kaiser HMO. See page 7 for more information about the HMOs. Contact the TBT Plan Administration Office to request a Kaiser 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.

REMINDER

To enroll in the Kaiser HMO offered through the Teamsters Benefit Trust, you must live in the HMO's service area. Detailed information about the Kaiser HMO option available through TBT may be found in separate disclosure materials. For information about the Kaiser HMO option, call the TBT Plan Administration Office.

You can also check the ***Comparison of Medical Benefits*** *for highlights of the Indemnity Medical and HMO option. However, refer to the separate materials 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 the Kaiser HMO option, your medical benefits are determined by the HMO (not by TBT).*

What is Covered

The Indemnity Medical option pays *Usual, Customary and Reasonable* (UCR) charges for medically necessary services and supplies authorized by a doctor for treatment of illness or injury to you or your covered dependents.

PPO Versus Non-PPO

The 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 Blue Cross PPO network providers are usually lower than charges for the same services by non-PPO providers. See your Blue Cross 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 80% of PPO contract rates for covered expenses. For most outpatient services, the Plan pays 80% of covered expenses for PPO providers and 50% of UCR charges 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 Blue Cross network, the Plan covers a lower percentage (usually 50%) 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 your TBT Plan's UCR limits, you pay for any extra amounts.

Note: *Because the extra amount is not a covered expense, its payment by you does not apply toward your copayment limit (out-of-pocket maximum) for the calendar year.*

How Benefits are Paid

-Preventive Care

PPO—100% of PPO Contract Rates (after $10 copayment)
or
Non-PPO—80% of UCR Charges
(Exam Only—100% of UCR Charges)

Your TBT Plan has both calendar year and two-year maximums for routine physical exam benefits (see your *Summary of Coverage*).

Preventive Care benefits include routine physical exams and related x-rays and lab work, pap tests, routine mammograms and PSA tests for detection of prostate cancer, flu shots, routine pediatric exams and immunizations as recommended by the American College of Pediatrics.

-Physician Benefits

PPO—80% of PPO Contract Rates
or
Non-PPO—50% of UCR Charges

Outpatient physician and surgery benefits include covered services of doctors, x-ray centers, clinical laboratories, physical therapy centers, and chiropractors. Most TBT Plans pay 80% of PPO contract rates for out-of-hospital covered benefits by PPO providers. However, if you use non-PPO providers, your TBT Plan usually pays 50% of Usual, Customary and Reasonable (UCR) charges. See your *Summary of Coverage* to confirm the percentages covered under your TBT Plan.

Note: *Sometimes the patient has no choice of providers but the Plan rules remain the same. 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 the non-PPO rate (50% of UCR charges).*

-Referral by PPO Providers

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

Exceptions: Non-PPO physician benefits mentioned on this page are paid at 80% of UCR charges (instead of 50%) in the following cases:

1. When a PPO physician *refers* you to a non-PPO provider for medically necessary tests, x-rays or laboratory work.
2. When a PPO physician performs surgery at a PPO hospital, but in-hospital services are provided and billed by non-PPO hospital staff (such as an anesthesiologist).

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

-Hospital Benefits

PPO—80% of PPO Contract Rates
or
Non-PPO—50% 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 will 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 50% of Usual, Customary and Reasonable (UCR) charges for an inpatient stay in a non-PPO hospital *when a PPO hospital is available within a 30-mile radius of your home.* These percentages apply only to inpatient hospitalization including miscellaneous hospital services (defined on page 19).

Any amount that you are required to pay due to use of a non-PPO hospital does not apply to your copayment limit (out-of-pocket maximum).

-A Few Exceptions

There are 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 50% 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. Benefits are always reduced by 50% when these services are provided by a non-PPO hospital (see *Mental Health Treatment* 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 (within the 72-hour maximum). Failure to obtain Pre-admission Certification will result in a reduction of benefits. Charges for non-certified hospital days are not covered under the Plan (see page 18 for more information).

-Outpatient Services

(Subject to Deductible)
PPO—80% of PPO Contract Rates
or
Non-PPO—50% of UCR Charges

In general, outpatient services are paid at 80% of PPO rates or 50% of UCR charges in a non-PPO hospital.

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.*

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 on page 15).

Most covered physician benefits are paid at a lower percentage of Usual, Customary and Reasonable (UCR) charges if you do not use PPO providers. If you use PPO providers, the benefits are paid at the higher PPO percentage (as explained on page 15).

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 the non-PPO percentage of 50% of UCR charges.

However, 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 Blue Cross toll-free 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 amount,* ***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 your TBT Plan. 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 also apply (see page 18).*

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 may result in up to a 50% loss of benefits depending on your TBT Plan. See your *Summary of Coverage* for details.

The Deductible

Under the Indemnity Medical option, the deductible is the amount you pay each calendar year before medical and prescription drug benefits are payable. The deductible amounts are listed in your *Summary of Coverage.*

Each eligible person covered under the Plan has separate PPO and non-PPO deductibles for covered medical/prescription drug expenses.

The Plan limits your family's calendar year deductibles (for both PPO and non-PPO providers). After you meet the family maximum deductibles listed in your *Summary of Coverage*, no additional PPO or non-PPO deductibles are payable for individual members of your family for the rest of the calendar year.

Deductibles also have a *carryover rule.* Any covered expenses that you or an eligible dependent incur during the last three months of the calendar year that apply to your deductible will also apply to your deductible for the next calendar year.

Your Share After the Deductible

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

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

Remember that you are responsible for paying any non-covered charges or any charges above Usual, Customary and Reasonable (UCR) if you use a non-PPO provider. Charges above UCR would be part of your copayment and paid by you.

Copayment Limit

If your covered expenses payable at your copayment percentage (for example at 80% or 50%) total your Plan maximum (see your *Summary of Coverage*) during any calendar year in which you have satisfied your deductible, covered expenses for the balance of the calendar year are paid at 100%. *However, you are still responsible for paying any non-covered charges, such as any charges above UCR if you use a non-PPO provider.*

The following expenses do not apply toward meeting your Plan's calendar year copayment limit:

1. The 20% copayment for a second alcohol or chemical dependency treatment.
2. The 50% copayment for an inpatient stay in a non-PPO hospital.
3. Non-covered expenses—such as charges by a non-PPO provider that are higher than Usual, Customary and Reasonable (UCR).

Exceptions Not Subject to Copayment

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

HOSPITAL REQUIREMENTS

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 will result in a 60% reduction of benefits. Charges for non-certified hospital days are not covered under the Plan.*

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 toll-free 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 treatment*, 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 will be 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 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 explained in the *Claiming Benefits* section beginning on page 39.

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 pages 20-21).

Case Management

Blue Cross Life and Health (the Plan's Utilization Review Organization) also reviews charges and appropriateness of 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 plans could include home, hospice or convalescent nursing home care.

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 benefits provided by a PPO hospital are paid at 80% of covered charges up to the calendar year maximum period explained in your *Summary of Coverage* and 100% thereafter. **Note:** PPO inpatient charges are not subject to the deductible. Check with the Blue Cross Prudent Buyer Network at (888) 887-3725 to make sure you are using PPO providers to get maximum benefits.

If you or your covered dependents are 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*.

However, all in-hospital care must be pre-authorized and monitored by the the Plan's Review Organization. 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 20. (In an emergency, the call must be made within 72 hours.)

Miscellaneous Hospital Services

The Plan pays:

- Up to 80% of PPO contract rates (or 50% of UCR charges if 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*. **Note:** Changes for non-PPO providers are also subject to the deductible.

The following *outpatient* hospital services are covered at 80% or 50% (after the deductible is met) depending on your TBT Plan (as explained in your *Summary of Coverage*):

- 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.

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 patient.
4. Room and board for the first 60 days of covered hospitalization in a convalescent hospital or skilled nursing facility. See *Skilled Nursing Facility or Convalescent Hospital* on page 20 for additional restrictions.
5. 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. Your Plan complies with this law and does not require prior authorization for hospitalization up to the time periods stated above.

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 your Plan's maximum limits (see *Mental Health Treatment* on page 20).

Other Covered Expenses

The following services are also covered up to the Plan's copayment percentages and maximum amounts. See the *Summary of Coverage* for details.

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 (including surgical bra) 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 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 benefit of $100 per lifetime.

Other Medical Benefits

-Preventive Care Benefits

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

-Skilled Nursing Facility or Convalescent Hospital

Room and board in a convalescent hospital or skilled nursing facility (see definition, page 60) 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 18).

All periods of convalescent hospital confinement during any single disability period (see *What is Total Disability?*, page 10) are considered one hospital stay.

Benefits for convalescent hospitalization shall not be higher than the facility's standard charge for a 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 Treatment

Inpatient and outpatient mental health treatment is covered the same way as any physical illness. Benefits are paid at 80% of PPO contract rates or 50% of non-PPO UCR charges for inpatient hospital charges. Professional services are paid at 50% of PPO contract rates or 50% of non-PPO UCR charges. Both inpatient and outpatient treatment is subject to your Plan's calendar year and lifetime maximums (listed in your *Summary of Coverage*) and the following limitations:

- ***Inpatient Days Maximum.*** Covered expenses for *in-hospital* mental health treatment are limited to 30 days per calendar year and 60 days per lifetime.
- ***Outpatient Per Visit Maximum.*** Covered expenses for out-of-hospital mental health treatment are limited to a certain number of visits per calendar year (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 as explained in the *Summary of Coverage*. Professional services are paid at 80% of PPO contract rates or 50% of non-PPO UCR charges.

- Supplements and supplies are not covered.
- Massage therapy is not covered.

-Alcohol or Chemical Dependency Treatment Benefits

Alcohol or chemical dependency treatment 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).
2. An inpatient or outpatient course of treatment for rehabilitation of alcoholism or drug abuse is paid subject to the covered expense maximum amounts 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 *two* courses of treatment per lifetime (whether inpatient or outpatient).

The first course of treatment is paid at 100% up to the covered expense maximum stated in your *Summary of Coverage*. The *second* requires a 20% copayment that does not apply to meeting the Plan's copayment limit per calendar year.

- 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 covered expense maximum listed in your *Summary of Coverage*.

-Stop-smoking Benefits

The Indemnity Medical option provides stop-smoking benefits to help participants and their covered dependents 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 Kaiser 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 the HMO option (if the Kaiser 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 reimbursed in the same way as other doctors' office visits.

Nicotine Patches

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

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

Note: *Since nicotine patches no longer require a doctor's prescription, TBT reimburses 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 the Kaiser 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 which 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 are 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 your TBT 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 provisions of their respective Plans.

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:

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 will 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, pap tests, routine mammograms, PSA tests for detection of prostate cancer, flu shots, routine pediatric exams and immunizations as recommended by the American College of Pediatrics. See your *Summary of Coverage* for your Plan's calendar year maximum. **Note:** *Diagnostic charges are not subject to the preventive care maximum.*
5. Well baby care, except as stated in #4 above (see *Preventive Care* on page 15).
6. Routine nursery care furnished to a newborn child during the period of the mother's postpartum hospitalization except such care provided during the first 48 hours following a normal vaginal delivery or during the first 96 hours following a caesarean section. This exclusion does not apply if the nursery care is furnished in connection with bodily injury or illness, including medically diagnosed congenital defects or birth abnormalities, *or if no separate charge is made for nursery care.*
7. 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 or physical complications in all stages of a mastectomy.
8. Dental services and supplies unless the expense is necessary for repair or alleviation of damage to natural teeth caused by an accident only if such services and supplies are provided within two years from the date of the accident *and* while still eligible.
9. Expenses incurred for prescription drugs and prescription medicines except while hospitalized.
10. Drugs and medicines dispensed in a doctor's office except *covered injections* provided during a doctor's office visit.
11. Weight control and nutritional counseling *except* when prescribed to treat a specific medical condition or for morbid obesity with disease etiology.
12. Any charges that result from or are related to any medical, surgical or dental procedure that is considered experimental in terms of generally accepted medical standards as determined by the Plan.
13. 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.
14. Intentionally self-inflicted injuries or medical conditions, unless the injury results from a medical condition.
15. Conditions caused by or related to an act of war, armed invasion or aggression.
16. 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 46.)

17. 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).

18. Any medical or dental 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 Part A or Part B.

19. 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 the HMO for which no charge would otherwise be made to the patient or which the patient is not legally obligated to pay).

20. Any charges that would not be made in the absence of this coverage.

21. Charges for itemized reports or itemized billing, except when requested by the Plan.

22. Charges for failure to keep a scheduled appointment.

23. Charges for services incurred before coverage was effective or after it terminates.

24. Services that are custodial in nature, rather than professional medical services prescribed by a doctor.

25. Nursing services provided by a family member or someone who lives in your home.

26. 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.

27. Purchase of durable medical equipment unless such purchase is determined appropriate by the TBT Plan Administration Office in advance and specifically pre-authorized by the Plan's Utilization Review Organization.

28. 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.

29. Speech therapy, occupational therapy or vision therapy, except when prescribed by a doctor to treat illness or injury.

30. Charges related to treatment for change of gender and/or any complications resulting from such treatment.

31. Procedures, services or supplies specifically excluded by the Plan now or in the future.

32. Vitamins, including *covered injections*, even when prescribed (unless medically necessary as determined by the Plan's Utilization Review Organization).

33. Sales tax.

34. Ambulance, including air ambulance, when not appropriate for the level of medical treatment required or solely for convenience.

35. Waterbeds or flotation beds.

36. Charges for any services relating to *alternative medicine*. This term refers to (but is not limited to) holism, homeopathic treatment, orthomolecular services and any other treatment of a similar kind.

37. Hypnotism.

38. Support stockings, except for initial pair prescribed by a doctor following surgery.

39. Orthotics, except for the initial pair prescribed by a doctor.

40. Treatment of Temporomandibular Joint dysfunction (TMJ). However, this treatment may be covered under your dental plan option (see page 39) subject to the copayment limit and maximum lifetime benefit listed in your *Summary of Coverage*.

41. Charges exceeding the Plan's maximum vision expense benefit. See your *Summary of Coverage* for details.

42. Eye refractions, eye glasses and lenses.

43. Radial Keratotomy (RK) and any other form of eye surgery intended to correct nearsightedness or astigmatism.

44. Hearing aids and related expenses.

INDEMNITY MEDICAL CLAIMS

How Indemnity Medical Claims are Paid

See *Claiming Benefits* (beginning on page 39) for details about claim filing and appeals procedures.

YOUR PRESCRIPTION DRUG BENEFITS

The TBT Prescription Solutions drug card program reimburses you for covered prescription drugs from participating pharmacies. Specific copayments, reimbursement amounts and mandatory mail service rules are explained in this section and your *Summary of Coverage*. To get the most from your coverage, you should present your prescription drug card at a participating pharmacy. 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 dependents become eligible for prescription drug benefits at the same time that you are eligible for your other TBT benefits (see pages 1-6).

Prescription Drugs for the Indemnity Medical Option Participants

Under the Indemnity Medical option, outpatient prescription drugs are provided by reimbursement through the TBT Plan Administration Office (after medical/prescription drug deductible is met) through Prescription Solutions as follows:

- Drugs from Prescription Solutions pharmacy (by reimbursement through TBT) are payable at 80% up to the Plan's prescription drug calendar year maximum per calendar year and 100% thereafter.
- Outpatient drugs through non-Prescription Solutions pharmacy (by reimbursement through TBT) are payable at 50% of UCR up to the Plan's prescription drug calendar year maximum per calendar year and 100% thereafter. **Note:** The amount reimbursed is usually less than retail charges at a non-Prescription Solutions pharmacy.)
- Participants must use the mail service after two fills at the retail pharmacy.

Prescription Drugs for Kaiser Participants

Plan VI requires that participants who enroll in the Kaiser HMO use only Kaiser facility pharmacies (except for an eligible out-of-area emergency). Outpatient prescription drug benefits are only provided by the Kaiser HMO facility or mail service (after a copayment is met per prescription or refill)—rather than through the TBT Indemnity Medical option prescription drug benefits.

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

Prescription Drug ID Card

When the TBT Plan Administration Office receives your *TBT Enrollment Form*, Prescription Solutions sends you a welcome package that includes program instructions, prescription drug ID cards, a list of participating retail chain pharmacies and a mail service brochure. Your prescription drug ID card lists only your name, but may be used by all your covered dependents. 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 plastic ID cards from Prescription Solutions. If you need an additional prescription drug ID card, you can request one by calling the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

If your covered dependent is a full-time student living away from home, you need to contact the TBT Plan Administration Office each semester to verify the student's eligibility for coverage as a full-time student. You also need to order the student's prescription drug ID card. (See pages 5-6 for more information about dependent coverage for eligible full-time students.)

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 the restrictions on pages 26-27. Also review your *Summary of Coverage* for information about copayments (if any) that 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 pages 26-27 of this guide. The most common prescription drug items covered include:

- Federal-legend drugs.
- State-restricted drugs.
- Compound 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 the FDA, (2) included under *What is Covered* above or (3) excluded under the heading *What is Not Covered* on pages 26-27. 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 prescription drugs 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 pages 26-27.

Mail Service Program

You must use the mail service program after the first two prescriptions or refills are ordered through retail pharmacies. The medicine is mailed directly to your home.

The same restrictions and exclusions that apply to the prescription drug program also apply to the mail service program. If you need a mail service form or information, contact the program directly at (800) 562-6223.

Prescriptions ordered through the Prescription Solutions Mail Service Program are covered at 80% by reimbursement.

If you (or your doctor) order a brand name drug when a generic equivalent is available, you pay the cost difference between generic and brand name (in addition to your copayment).

If You Need Injectable Medication

Injectable medication (except those listed on this page under Injectable Exceptions) 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 the Kaiser HMO that requires you to use the Kaiser pharmacy only for your prescriptions. Contact the Kaiser 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 covered 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 (and collect any co-payment if applicable).

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. Outpatient prescription drugs are provided by reimbursement through the TBT Plan Administration Office (after the medical/prescription drug deductible and copayment are met).

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 dependents must use this card at a Prescription Solutions pharmacy to receive maximum prescription drug benefits (see *Using Non-Participating Pharmacies* to the right).

Reimbursement Procedures

Use a TBT prescription drug reimbursement claim form. The TBT Plan Administration Office can send you a form upon request. **Note:** Send your completed claim form to the TBT Plan Administration Office.

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*, are reimbursed at 80% 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 will be reimbursed at 50% of UCR.

How the Mail Service Program Works

Getting started is easy. You may (1) Call (800) 562-6223 to provide the prescription information and request that your doctor be contacted for a new prescription; or (2) If you prefer ordering by mail, you can complete the enclosed prescription order form and submit it with your payment and prescriptions. **Note:** You may call (800) 562-6223 to request the amount that should be sent for your payment.

MEDICARE PART D

If you or a covered dependent are Medicare-eligible, but currently covered under a TBT plan for active employees (either under the Indemnity Plan or the Kaiser HMO), ***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****.*

What is Not Covered

The Plan covers only medication that is medically necessary and prescribed by your doctor. 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 and other smoking cessation aids (unless after completion of a Plan-approved stop-smoking program—see page 21).
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 are Usual, Customary and Reasonable (UCR).
9. Fluoride tablets and non-therapeutic vitamins and minerals, including prescribed vitamins such as *Tri-Vi-Sol* and *Poly-Vi-Sol* (unless medical necessity is clearly established).
10. Vitamins (including federal-legend vitamins) even when prescribed—unless medical necessity is clearly established, as in prenatal vitamins during pregnancy).
11. Anabolic steroids.
12. Growth hormones (unless pre-approved by the Plan's Utilization Review Organization).
13. Fertility drugs.
14. Allergy serums.
15. 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.
16. Genetically engineered drugs and immune altering drugs (even when injectable) unless pre-approved by the Plan's Utilization Review Organization.
17. Immunization agents, biological sera or plasma.
18. Diet medications, appetite suppressants, dietary or nutritional supplements and liquid diet food that may be purchased with or without a prescription.
19. 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 *Covered Expenses*, item 7 on page 20).
20. Charges for an unreasonable supply of drugs (or more than the maximum 100-day supply).
21. Refills not authorized by the prescribing physician.
22. Refills requested sooner than appropriate after last filled.
23. Drugs or medicines dispensed a year or more after the prescription date.
24. Claims not filed within one year of purchase.
25. Prescriptions filled before coverage begins or after it ends.
26. Drugs or medicines prescribed for conditions or treatments not covered by the Plan.
27. Investigational or experimental drugs.
28. Charges to administer prescription drugs or insulin injections.
29. Drugs or medicines that have not been fully approved by the U.S. Food and Drug Administration (FDA).

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 39) for details about claim filing and appeals procedures.

YOUR DENTAL CARE BENEFITS

Regular dental care is an important part of your overall health. You may choose one of the dental options shown on your Dental Option Form sent to you when you first enroll or during Open Enrollment. The current options include Delta Dental, Bright Now! Dental/Newport Option and Pacific Union Dental.

See the *Comparison of Dental Benefits* and review the current options. You can also consult your *Summary of Coverage* for details about your benefits.

The *Comparison of Dental Benefits* is a summary only. It does not fully describe your benefit coverage. For details on Delta Dental or the other TBT dental options, refer to the *Evidence of Coverage* for Delta Dental, Bright Now! Dental/Newport Option or Pacific Union Dental. The *Evidence of Coverage* is the binding document between the dental program and its members. (To obtain a copy of the dental brochures or each provider's *Evidence of Coverage*, call the TBT Plan Administration Office.)

The dental provider's treating dentist must determine that the services and supplies are necessary within accepted dental standards to prevent, diagnose or treat your dental condition. The services and supplies must be provided, prescribed, authorized or directed by a dental program dentist. (To obtain a copy of each provider's list of dentists, call the TBT Plan Administration Office.)

For details on the benefit and claims review and decision procedures for your dental option, refer to the respective dental program's *Evidence of Coverage*.

Dental Options

Indemnity Dental (Option 1) is TBT's dental option that is administered by Delta Dental. Under Option 1, you may see the licensed dentist of your choice. The level of Plan benefits depends on whether your dentist is a Delta Dental dentist.

Note: *During your first year of TBT coverage, you may only choose Option 2 or Option 3 unless you qualify for Option 1 under one of the exceptions listed on the* ***Dental Option Form****.*

Option 2 (currently Bright Now! Dental/Newport Option) and Option 3 (currently Pacific Union Dental) are the other dental options offered through TBT (at the time this guide is printed). Both Option 2 and Option 3 are *prepaid* dental plans providing covered services through designated dental offices throughout California. See your *Comparison of Dental Benefits* and *Summary of Coverage* for details about the current TBT-provided dental plan options.

When Coverage Begins

You and your covered dependents become eligible for dental benefits at the same time that you are eligible for your other TBT benefits (see pages 1-6).

Coverage begins only ***after*** you choose a dental option by sending a completed *TBT Enrollment Form* and *Dental Option Form* to the TBT Plan Administration Office. It is not automatic.

The dental option you choose also applies to your covered dependents.

> ***REMINDER***
> *All TBT dental options cover a wide range of services and supplies. For more information, see your* ***Summary of Coverage*** *and* ***Comparison of Dental Benefits****.*

If You are a Newly Hired Employee (with a Currently Participating Employer)

The Indemnity Dental option (Option 1) is not available to you until one year after your initial hire date. (See your ***Enrollment Materials*** *folder and* ***Dental Option Form*** *for specific enrollment rules and exceptions.) Until then, you may enroll in one of the prepaid dental options (Option 2 or Option 3) listed on this page. Brochures describing TBT's current dental options are provided in your new employee packet or upon request.*

The remaining pages of this section describe dental benefits under the Indemnity Dental option.

How to Use the Indemnity Dental Option

The Indemnity Dental option covers a wide range of services as long as they are necessary and provided by a licensed dentist or dental hygienist.

To encourage regular visits to your dentist, there is no deductible for *preventive care*. Your TBT Plan may require that dental deductibles are met before paying other types of expenses under the Indemnity Dental option.

Check your *Summary of Coverage* and *Comparison of Dental Benefits* for details about deductibles, copayments and maximums that may apply to your dental benefits.

After you satisfy the deductible amounts listed in your *Summary of Coverage*, the Indemnity Dental option provides payment for covered expenses at your TBT Plan's dental copayment percentage for the rest of the calendar year. (See your *Summary of Coverage* for your copayment percentage.)

The Indemnity Dental option may have maximum amounts that apply to each covered person in a calendar year. (See your *Summary of Coverage* for your Plan maximums.)

IMPORTANT WORDS

Certain words in this section have meanings specific to the Indemnity Dental option. They are listed here for your convenience. These and other important terms are also defined near the end of this guide.

***Covered Expenses** are the Usual, Customary and Reasonable (UCR) charges for necessary services performed by a dentist in the geographic area where you receive the dental care. Charges that the Indemnity Dental option considers to be higher than the UCR charges for a similar procedure in your geographical area are not covered.*

***Covered Services.** The specific dental service covered according to TBT's administrative contract with Delta Dental.*

***Contract.** A written agreement between TBT and Delta Dental to provide you and your covered dependents with dental benefits. That contract, along with this guide, your **Summary of Coverage** and **Comparison of Dental Benefits** establish the terms and conditions of the dental benefits that you receive.*

***Maximum.** The highest dollar amount that will be paid for covered dental procedures in any calendar year, or lifetime, for certain types of benefits.*

***Usual, Customary and Reasonable (UCR).** A usual fee is the amount that a dentist regularly charges and receives for a given service, or the fee actually charged, whichever is less. A customary fee is within the range of usual fees charged and received for a particular service by similarly trained dentists in the same geographic area. A reasonable fee is ordinarily what is usual and customary, but the Plan may conclude that a higher fee is justified for particular dental work that requires an extraordinary level of complexity. See your **Comparison of Dental Benefits**.*

Delta Dentists

When you enroll in the Indemnity Dental option, you have the freedom to go to any licensed dentist you choose. However, you receive the highest covered benefits when you use dentists who participate in the Delta Dental network.

While most dentists licensed in California participate in Delta Dental, you should ask your dentist if he or she is a Delta Dental provider so you will get the maximum benefits for the lowest out-of-pocket costs.

A list of Delta Dental's dentists can be obtained by calling their toll-free number at (800) 765-6003. You can also visit their web site at www.deltadentalca.org or call their provider finder service at (800) 427-3237.

Covered Expenses - Indemnity Dental Option

The Indemnity Dental option covers the services listed below. (Refer to your *Comparison of Dental Benefits* for deductible amounts, copayments, benefit maximums and other limits specific to each category.) Also see *Limitations* and *Exclusions* on pages 30-32. Be aware that if there are alternative dental procedures or techniques with different fees, the Indemnity Dental option only pays for the treatment with the lower fee.

- Preventive Care

The Indemnity Dental option covers preventive care to help your dentist determine necessary treatment and to prevent deterioration of your teeth and gums. Preventive care services (on next page) are not subject to the deductible under your TBT Plan (as explained in your *Summary of Coverage*).

Preventive care includes:

- Two oral examinations, per calendar year (including office visits for observation and/or specialty consultation) that include cleaning, scaling, polishing and fluoride treatments.
- Full-mouth x-rays, once every five years.
- Bitewing x-rays, no more than twice in a calendar year for covered children up to age 18 and once in a calendar year for covered adults.

- Basic Care

Basic care includes procedures needed to restore your teeth, oral surgery and endodontic services such as root canals and periodontal procedures. Periodontal procedures that include cleanings are subject to the *same* limits as other dental cleanings. Cleanings of any kind are covered no more than twice in a calendar year.

Basic care includes:

1. Anesthesia (for covered oral surgery procedures).
2. Extractions and oral surgery.
3. Treatment of periodontal disease and other gum or mouth tissue disorders.
4. Root canal therapy and other endodontic treatment.
5. Amalgam, silicate or composite (resin) restorations.
6. Installation of space maintainers, including adjustments during the first six months.
7. Sealants for children applied only to permanent first molars through age eight and second molars through age 15 if teeth are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of application.

Copayments vary by TBT Plan. (Check your *Summary of Coverage* and *Comparison of Dental Benefits* for the amounts that may apply to your dental coverage.)

- Major Care

Major care is more costly restorative treatment such as bridgework and crowns. Copayments (if any) for these services may differ.

Major care includes:

1. Crowns, caps, inlays, onlays and cast restorations needed to treat cavities that cannot be replaced by amalgam, silicate or direct composite (resin) restorations.
2. Prosthodontic benefits, including the construction or repair of fixed bridges, partial dentures and complete dentures, if provided to replace missing natural teeth. The Plan pays the applicable percentage of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture. (**Note:** A standard complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth constructed using accepted and conventional procedures and materials.)
3. Certain non-surgical procedures to treat Temporomandibular Joint Dysfunction (TMJ) as explained in your *Summary of Coverage* and *Comparison of Dental Benefits*. Your TBT Plan pays 50% of specific covered TMJ charges up to a lifetime maximum of $1,000.

What Is Not Covered

The Indemnity Dental option covers a wide variety of dental care services, but certain expenses are not covered. See the *Limitations* and *Exclusions* that begin below. (Check your *Summary of Coverage* and *Comparison of Dental Benefits* for any special rules or exceptions not mentioned in this guide.)

- Limitations

The Plan limits certain dental benefits as follows:

1. Benefits are not payable for more than two oral examinations, including office visits for observation and specialist consultations (or a combination).
2. Benefits are not payable for more than two prophylaxis (except during pregnancy), fluoride treatments or procedures that include cleanings in a calendar year.
3. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over. Full-mouth x-rays are provided once in a five-year period.

4. Sealant benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if teeth are without caries (decay) or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
5. Crowns, caps, inlays, onlays and cast restorations are covered benefits on the same tooth only once every five years.
6. For a standard cast chrome or acrylic partial denture or a standard complete denture, the Plan pays its copayment percentage of the dentist's fee allowance (the average amount charged by most participating dentists). A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.
7. Prosthodontic devices are covered only once every five years, and only if there has been such an extensive loss of remaining teeth, or a change in supporting tissues, that the existing appliance cannot be made satisfactory.
8. Treatment of Temporomandibular Joint Dysfunction (TMJ) must be authorized in advance and is limited to a lifetime maximum of $1,000 after your copayment percentages are met. Covered expenses are paid at 50% if Delta dentist or 50% of UCR charges if non-Delta dentist. Covered expenses are payable at 50% for temporary repositioning appliance, occlusal guard, occlusal adjustment (complete) or removable metal overlay stabilizing appliance. Benefits are pre-approved based upon the treating dentist's documentation of the treatment plan and the need for the proposed treatment as determined by the Plan.
9. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee. For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.
10. Diagnostic casts are a benefit only when made in connection with subsequent treatment covered by this Plan.

- Exclusions

Benefits are *not* payable for the following exclusions:

1. Treatment before the patient was eligible for Plan benefits or after coverage terminates.
2. Charges higher than those considered by the Plan to be Usual, Customary and Reasonable (UCR).
3. Treatment that is not provided by a legally qualified dentist, except for services within the scope of a dental hygienist's license under a dentist's supervision.
4. Treatment for injuries covered by Workers' Compensation or employer liability laws, or services that are paid by any federal, state or local government agency, except Medi-Cal benefits.
5. Dental treatment for cosmetic purposes (unless the expense is necessary to repair damage from an accident only if such dental treatment takes place no later than two years from the date of the accident and while still eligible).
6. Replacement of a crown, bridge or denture for which benefits were already paid by TBT within the past five years, unless the replacement of the crown, bridge or denture is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or if the device is a stay plate or similar temporary partial bridgework and is being replaced by a permanent device; or the prosthesis is damaged beyond repair as a result of injury while in the mouth.
7. Expenses for facings on crowns or pontics posterior to the second bicuspid.
8. Temporary or permanent replacement of an existing prosthodontic device that could be made satisfactory.
9. Medical treatment for conditions caused directly (and independently of all other causes) by external, violent and accidental means. Such conditions may be covered under your TBT medical option (see information beginning on page 14).
10. Treatment for conditions that are the result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

11. Treatment which (1) restores tooth structure that is worn, (2) rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion, or (3) stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
12. Prescribed drugs (see *Your Prescription Drug Benefits* beginning on page 24).
13. Hospital costs and any other fees charged by a dentist for hospital treatment.
14. Experimental procedures.
15. Anesthesia (except general anesthesia given by a dentist for covered oral surgery procedures).
16. Grafting tissues from outside the mouth to tissue inside the mouth (extraoral grafts).
17. Fees for specialized techniques involving precision dentures, personalizing or characterization.
18. Dietary planning.
19. Training in oral hygiene or preventive dental care.
20. Treatment for services or oral surgeries that are covered under your TBT medical option.
21. Hypnosis.
22. Charges for failure to keep scheduled appointments.
23. Expenses for which there is no legal obligation to pay.
24. Adjustments or relining of a crown, bridge or denture within six months after it was first provided. This includes any supplies provided in connection with such procedure, except that x-rays and regular cleanings are not considered to be part of the dental procedure.
25. Replacement of a crown, bridge or dentures that are lost or stolen.
26. Treatment other than full dentures that are needed solely to change the vertical dimension of teeth.
27. Treatment for conditions or services otherwise limited or excluded by the Plan.

What Else You Should Know

-Pre-Treatment Estimates

If you or a covered dependent need major dental work, your Delta dentist should send a *Pre-Treatment Estimate* Form to Delta Dental before treatment begins. Then you'll know how much the Indemnity Dental option pays—and how much you'll be expected to pay—before treatment begins. In a few days, Delta Dental returns the estimate to your dentist.

If you decide to begin the treatment, you can make the appointments you'll need. Any difference between amounts the Indemnity Dental option pays and the dentist's charges are your responsibility.

-Prescriptions from Your Dentist

(See *Your Prescription Drug Benefits* beginning on page 24.)

-Coordination of Dental Benefits

Coordination of Benefits rules apply whenever you or a covered dependent has coverage under a TBT dental option in addition to another dental plan. Coordination of Benefits rules are explained on pages 44-45. Benefits from the Indemnity Dental option may be reduced by the amount of any benefits for the same expenses provided by another group plan or government program (including Medicare) under which you or your eligible dependents are covered.

-Extended Benefits

If coverage under the Indemnity Dental option stops for you or your covered dependents because your coverage ends, you die or change job status, benefits may be paid for covered expenses that were part of a dental procedure that began when you were still eligible for benefits.

Extended benefits are usually covered as long as the services are received within 30 days after dental coverage ends. Preventive treatment (such as teeth cleaning or x-rays) is not considered to be the beginning of any other dental procedure.

Here are a few examples of procedures that may require extended benefits:

1. An impression made for a crown or to fix a bridge or denture.
2. A tooth prepared for a crown, bridge or gold restoration.
3. A tooth opened to prepare for root canal work.

-Continuing Coverage When It Ends

(See *When Coverage Ends* on page 8.)

You may be able to continue dental coverage through COBRA (beginning on page 10 for more information on COBRA coverage).

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 39) for details about claim filing and appeals procedures.

About the Prepaid Dental Options

The TBT Board of Trustees has contracted with two prepaid dental plans to provide dental care to eligible participants and their covered dependents. At the time this guide was printed, these options are:

- Bright Now! Dental/Newport Option (Option 2)
- Pacific Union Dental—PUD (Option 3)

If you choose one of these two dental options, you and your covered dependents must receive dental care services from that dental program's offices.

If you choose Pacific Union Dental, you must choose (and be accepted by) one of the Pacific Union Dental offices for coverage for you and your eligible dependents.

IMPORTANT

You and your dependents cannot enroll in different TBT dental options.

With either of the prepaid dental options, all your dental care must be performed by your provider's dental office.

If you enroll in one of the prepaid dental options, the only dental benefits covered are for services or supplies provided by that dental option's dentists.

There may also be limits on how often you can switch to another dentist or dental office within the dental option you select—as determined by each prepaid dental plan.

There is usually no copayment for ordinary or routine dental treatment (as long as it is provided at the specific office locations). But special charges apply to some services.

If you enroll in one of the prepaid dental options (currently Bright Now! Dental/Newport Option or Pacific Union Dental) you won't have to file any dental claim forms. If you are responsible for a portion of the charges, you are asked to pay the amounts you owe when services are provided.

You should check your dental option's specific brochures about covered services, patient charges, participating dentists and special limitations under your dental option before receiving care. Also review the *Comparison of Dental Benefits* in this package.

-Limitations and Exclusions

The prepaid dental options are subject to most of the same limitations as the Indemnity Dental option. There are also special limitations and exclusions specific to each dental option (explained in your *Comparison of Dental Benefits*). Each dental option has specific restrictions regarding types of dental services, emergency dental treatment and specialized care. These restrictions are not the same for each option and may change from time to time. There may also be changes in offices or available dental staff.

Check each dental option's separate brochures for specific restrictions regarding dental treatment, specialist and emergency services. Keep in mind that not all restrictions are listed in these materials. Check the separate disclosure information provided by each dental option or your specific dental office for the most current details. This information also explains the dental options' claim filing and appeal procedures.

REMINDER

Before having any work performed, it's a good idea to ask the dentist if you are responsible for any charges.

IMPORTANT

After your initial election of dental options, you may make changes to your dental options once every 12 months. Each time you change an option, a new 12-month period begins. You and your eligible dependents must be covered under the same dental options.

Note: *You will not be sent dental option change forms unless you request them. There are no annual mailings.*

Check the ***Comparison of Dental Benefits*** *and your* ***Enrollment Materials*** *folder. You should also refer to the special materials and provider lists from each prepaid dental option (available by calling the TBT Plan Administration Office).*

YOUR VISION CARE BENEFITS

Vision care benefits are provided through the Vision Service Plan (VSP) network. VSP has one of the most extensive vision care networks, with more than 20,000 licensed opticians, ophthalmologists and optometrists in the U.S.

You may choose any licensed eye care professional, but the paid benefit amounts will be greater when you use a VSP provider. You and your covered dependents don't have to use the same eye care professional. Each of you may choose a different eye care professional for covered benefits at any time.

When Coverage Begins

You and your covered dependents become eligible for vision care benefits at the same time that you are eligible for your other TBT benefits (see pages 1-6). You have vision care benefits no matter which medical or dental options you choose.

IMPORTANT

If you need treatment from an eye doctor for a non-occupational injury, surgery or medical condition affecting your eyes, refer to the medical section on pages 14-23. If an eye injury or illness results from work or working conditions, contact your Employer for information about Workers' Compensation benefits.

What is Covered

The vision care benefits are designed to encourage you to have regular eye exams and to help pay for prescription lenses and frames or contact lenses. These benefits are provided when you or your covered dependents see an eye care professional for an exam or need vision care materials or supplies.

You no longer need to request a VSP form in advance to visit a VSP provider. But it's critical that you mention your TBT coverage is through VSP before making a vision care appointment. The VSP provider contacts a VSP representative in advance of your visit to find out about your coverage and eligibility.

How to Use VSP

Step 1. Before making an appointment, read this section of the guide and make sure you understand your Plan benefits. Also check your *Summary of Coverage* for details about your vision care coverage.

Step 2. Contact a VSP provider and make an appointment. Identify yourself as a VSP patient in advance and provide your Social Security number. If you need help locating a VSP provider, call VSP at (800) 877-7195. As long as you are eligible, you'll be given a list of VSP eye care professionals in your area, so you can make an appointment.

Step 3. The VSP provider that you contact calls Vision Service Plan and receives advance authorization to provide your covered services, materials or supplies. If you are not currently eligible for vision care benefits, the VSP provider notifies you of this, usually before your visit.

Step 4. At the visit, the VSP provider has the patient sign the benefit form and provides a copy for your records. VSP providers agree to accept this signed form as full payment for covered expenses. (You may have to pay for any non-covered expenses—see page 36 for what is not covered.) Then, the eye care professional receives payment from VSP. You do not need to file claims. VSP pays its providers directly for covered services, materials or supplies listed in the charts on pages 35 and 36.

IMPORTANT

Don't forget to identify yourself in advance as a VSP patient. If you don't do so before receiving vision care services, materials or supplies, the VSP provider is NOT required to accept the Plan's benefit amounts as payment in full for covered services. (You are always responsible for payment of non-covered expenses.)

If You Choose Not to Use VSP Providers

Follow these steps if you receive services, materials or supplies from a non-VSP provider.

Step 1. When you use a non-VSP eye care professional, you must pay the full amount charged for your services, materials or supplies and send the itemized bill to Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-0001 (within six months of the date of service). You must include the following information:

1. The name of your Plan (listed on the cover of your *Summary of Coverage*).
2. Your name and mailing address.
3. Your Social Security number.
4. If a covered dependent, the patient's name, date of birth and relationship to you.

Step 2. VSP processes your claim and sends the reimbursed amounts directly to you. Reimbursed amounts cannot be made payable to the eye care professional. VSP only reimburses you for covered services and materials—and only at the specific non-VSP rates listed in the charts on this page and on page 36—if you file within the six-month deadline. You are not reimbursed for non-covered items.

You may be charged the standard fee for these services and you will also have to pay the eye care professional directly at the time of your visit and send back the claim form for reimbursement at the non-VSP rates listed in the charts on this page and on page 36.

REMINDER

You don't need to file claims if you use VSP providers. You also receive greater benefits. VSP member doctors are also required to verify the accuracy of the finished lenses.

Vision Care Services

The Plan covers a wide range of vision care services. As you can see, benefits are greater when you use VSP providers:

Exams and Eyeglasses	VSP Provider	Non-VSP Provider
Vision exam once every 12 months	Covered in full within allowance	$35 maximum benefit
Single vision lenses (standard size) one set every 12 months if prescribed	Covered in full within allowance	$25 maximum benefit
Bifocal lenses one set every 12 months if prescribed	Covered in full within allowance	$40 maximum benefit
Trifocal lenses one set every 12 months if prescribed	Covered in full within allowance	$50 maximum benefit
Lenticular lenses one set every 12 months if prescribed	Covered in full within allowance	$100 maximum benefit
Basic frames new frames once every 24 months	Covered in full within allowance	$30 maximum benefit
Tint	Pink #1 or #2	$5 maximum benefit

IMPORTANT

VSP patients may buy additional pairs of prescription glasses at a 20% discount. The Plan also provides a 15% discount on contact lens professional services. These discounts are available for 12 months following the patient's last covered eye exam from the same VSP provider. Ask your VSP eye care professional for details.

If You Prefer Contact Lenses

You may want to receive benefits (shown on the following page) for contact lenses instead of eyeglasses and an exam. However, your VSP provider must get advance approval from VSP before prescribing medically necessary contact lenses.

If the contact lenses are approved ahead of time by VSP, on the basis that the condition of your eyes makes contact lenses medically necessary, contact lenses and examination are covered in full.

However, if the condition of your eyes does not make contact lenses medically necessary, the Plan covers the comprehensive eye exam determining overall eye health and refractive state in full. Your $120 contact lens allowance is applied towards any contact lens fitting/evaluation and contact lens materials.

REMINDER

If you select services, materials or supplies that cost more than the Plan allows, you pay the extra charges.

Cosmetic Options

Your TBT vision benefits are designed to correct your vision rather than to supply cosmetic materials. You are responsible for any extra cost for certain services or supplies if you select any of these cosmetic options:

1. Blended lenses.
2. Oversize lenses.
3. Contact lenses (except as noted above).
4. Progressive multifocal lenses.
5. Chromatic, photochromatic or tinted lenses (except pink #1 or #2).
6. Coated or laminated lenses.
7. Frames that cost more than basic VSP frames.
8. Special low vision care treatment above maximum of $1,000 every 24 months.
9. Non-prescription or plano lenses.
10. Optional cosmetic processes.
11. Ultraviolet protected lenses.

What Is Not Covered

In addition to the cosmetic items listed on this page, benefits are not payable for the following vision services or supplies:

1. Orthoptics, vision training or any associated supplemental testing or vision aids.
2. Lenses and frames that are lost or broken, except at the normal replacement intervals explained in this section.
3. Two pairs of glasses in lieu of bifocals.
4. Medical or surgical treatment of the eyes.
5. Any eye examination or corrective eyewear (or related service or material) that is required by your Employer as a condition of employment.

Contact Lenses	VSP Provider	Non-VSP Provider
Medically Necessary • Following cataract surgery • To correct extreme visual problems that cannot be corrected with eyeglasses • To correct certain conditions of anisometropia and keratoconus (the doctor must obtain prior approval from VSP)	Covered in full in lieu of all other benefits (exams, lenses and frames)*	$250 maximum benefit (includes cost of exam, contact lenses and any other materials)
Cosmetic • Not medically necessary as defined above • In lieu of all other benefits	The Plan covers cost of the examination in full and no more than $120 of the cost of any contact lens fitting/evaluation and contact materials	The Plan covers up to $35 for the eye examination and no more than $100 for contact lens fitting/ evaluation and contact lens material

** Eligibility for exam and lenses is limited to once every 12 months and once every 24 months for frames. (see Vision Care Services on page 35.) These limits apply even if lenses or glasses are lost or stolen.*

6. Services or materials provided by any other vision care plan or group benefit program.
7. Services or materials provided as a result of any Workers' Compensation law, or similar legislation, or obtained through or required by any government agency or program.
8. Services or materials subject to exclusion under any other provision explained in this guide or other printed materials.

IMPORTANT

Vision benefits are also subject to any other exclusions mentioned in this guide or your ***Summary of Coverage****.*

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 39) for details about claim filing and appeals procedures.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Teamsters Benefit Trust provides employee life protection as well as benefits in the event you die or are severely injured through an accident. The amount of these benefits is stated in your *Summary of Coverage*.

When Coverage Begins

You become eligible for life insurance benefits at the same time that you are eligible for your other TBT benefits (see pages 1-6).

What is Covered

Life insurance benefits are payable upon your death. The accidental death and dismemberment benefits are payable in the event of an accident (see page 56 for definition of accident) which directly and exclusively results in death or dismemberment.

Your Plan provides Accidental Death and Dismemberment (AD&D) coverage for accidents that result in your:

1. Death.
2. Loss of any two: Hand, foot, sight of one eye.
3. Loss of one hand and one foot.
4. Loss of one hand and sight of one eye.
5. Loss of one hand or one foot.
6. Loss of sight in one eye.

With regard to a hand or foot, a *loss* means the complete severance through or above the wrist or ankle joint. *Loss of sight* means a total and irrecoverable loss of sight.

IMPORTANT

If you have more than one loss due to a single accident, payment is made only for the loss with the largest benefit. Payment will be made only for a loss that results from the accident, without regard to any former loss.

What is Not Covered

Life insurance benefits are payable following the covered person's death by any cause. However, AD&D benefits are not payable for losses that are counted or contributed by:

1. Disease.
2. Illegal drug, chemical, poison or inhalation of gas.
3. Injury that is sustained:
   - in the course of any medical or dental diagnosis or treatment, including the therapeutic use of nuclear energy, or
   - while you are in or upon any aircraft, unless you are a fare-paying passenger on a regularly scheduled flight.
4. Injury that is intentionally self-inflicted while sane or insane.
5. Injury that results from:
   - any act of war, or
   - your commission of a crime, or
   - any release of nuclear energy.

Naming Your Beneficiary

You designate your beneficiary for life insurance and accidental death and dismemberment benefits on the *TBT Enrollment Form*. Benefits are payable to the beneficiary named on this form in the event of your death, regardless of the cause.

You may designate any person you wish as your beneficiary. You can name more than one person or even your estate, but you must use the official *TBT Enrollment Form* for this designation.

You may change your beneficiary at any time by sending a new *TBT Enrollment Form* to the TBT Plan Administration Office. No change becomes effective until this replacement form is received by this office. Beneficiary designations made on forms used by pension or other health and welfare plans are not accepted by this Plan. Contact the TBT Plan Administration Office if you need a *TBT Enrollment Form*.

Claim Filing Deadline

Claims should be filed as soon as reasonably possible. The TBT Plan Administration Office can send their application for benefits form and help with the claim filing process. The TBT Plan Administration Office must receive the completed form no later than 12 calendar months after your death.

In no event, except in the absence of legal capacity, will proof be accepted later than 12 calendar months after injury or death.

Life insurance claims must contain a certified copy of the death certificate *with an embossed seal*. If the death is caused by an accident, a copy of the accident report must also be supplied with the application. An application for accidental dismemberment benefits must also contain proof of accidental injury.

REMINDER

It's a good idea to let your family know about your Teamsters Benefit Trust insurance protection. Keep a copy of your ***TBT Enrollment Form*** *with your other important records.*

Make sure that your beneficiary knows how to contact the TBT Plan Administration Office in case of your death.

Note: *A change in marital status does not automatically change your beneficiary designation. If you want to cancel your previous designation and name someone else, you must fill out a new* ***TBT Enrollment Form*** *and send it to the TBT Plan Administration Office.*

Extension of Benefits

If you are under age 60, and you become *totally disabled* while covered, your life insurance benefits may be extended for up to one year, even though you are not working (see page 10 for a definition of *total disability*).

This extension may be renewed annually if you provide proof to the insurance company that you are still totally disabled within the three-month notice period before the anniversary of the date when your total disability began. Total disability is considered to have ended if you do any work for pay or gain.

Conversion Privileges

You may convert your life insurance to an individual policy within 31 days after your TBT coverage ends. Upon request, the TBT Plan Administration Office sends you the forms required to apply for a conversion policy. No medical exam is needed to begin an individual policy if you *apply for and pay* the required premium within the 31-day conversion period.

The individual policy *will not be the same* as your group coverage through TBT. Your premium will be based on your age, risk factors and the insurance company's rates.

If you die during the conversion period, your benefits will be payable to the beneficiary listed on your *TBT Enrollment Form*.

Claim Filing Procedures

See *Claiming Benefits* (beginning on page 39) 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 Kaiser HMO facilities in your usual service area (see the Kaiser HMO's *Evidence of Coverage* for more information).
- *Indemnity Dental benefits.* When you use Delta Dental providers.
- *Prepaid dental benefits.* When you use their providers and facilities.
- When your Plan requires that Kaiser Enrollees use Kaiser pharmacy only.

Claims must always be filed for Indemnity Medical benefits, whether you use a PPO or non-PPO hospital, doctor or other provider. However, the provider *usually* sends the claim to TBT. Hospitals always handle claim submission. *Check that your doctor or other provider will send in the claim. If not, it is your responsibility.*

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

- *HMO benefits.* When you travel or receive benefits outside your usual Kaiser HMO service area (see the Kaiser HMO materials for more information).
- *Prescription drug benefits.* You must present your TBT Prescription Solutions ID card at a participating pharmacy for maximum reimbursement.

Send the receipts for covered prescription drugs to the TBT Plan Administration Office (along with the participant's name and ID information contained on the Prescription Solutions plastic ID card). The participant's name appears on the card, but it may be used by all covered dependents.

If you are a new participant and have not received your plastic prescription drug card, you can use the temporary ID card enclosed with this *Guide to Your Benefits*. If you use a non-Prescription Solutions pharmacy. Separate direct reimbursement claim forms are required for you and your covered dependents. Check with the TBT Plan Administration Office to make sure you are using a participating pharmacy to receive maximum reimbursement from TBT. (See *Reimbursement Procedures* on page 26.) **Note:** Kaiser HMO participants receive prescription drugs at the Kaiser pharmacies only.

- *Vision care benefits.* When you don't use VSP providers. Send itemized bills for covered services to the Vision Service Plan. You are reimbursed for covered expenses up to the maximum amount listed in your *Guide to Your Benefits* on pages 35 and 36. See page 35 for the Vision Service Plan address.
- *Life insurance and accidental death & dismemberment benefits.*

How to File a Claim

1. If you need to file a claim, you can request the appropriate form through the TBT Plan Administration Office. Some claim forms are 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.
4. Mail the completed form with any related bills or statements to the address printed on the claim form within 60 days of the date the claim was incurred (and 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, processing of your claim will be delayed.

Life insurance or AD&D insurance claim filing deadline. Life insurance or AD&D insurance claims must be filed within 365 days of the death or accident. Contact the TBT Plan Administration Office for these forms, or if you or your beneficiaries need help filing a claim.

The TBT Plan Administration Office can send an application for benefits and help with the claim filing process. The TBT Plan Administration Office must receive the completed application no later than 12 calendar months after your death.

In no event, except in the absence of legal capacity, will proof be accepted later than 12 calendar months after the covered person's injury or death.

Life insurance claims must contain a certified copy of the death certificate with an embossed seal. If the death is caused by an accident, a copy of the accident report must also be supplied with the application. An application for accidental dismemberment benefits must also contain proof of accidental injury.

Late Claims

If a claim form is required (and you don't send it in within 365 days if the claim is for life insurance or AD&D benefits), the claim will not be reduced or denied if it is shown 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.*

How to File an Indemnity Dental Claim

-How Indemnity Dental Claims are Paid

No claim forms are needed when you use Delta Dental providers. Your dentist bills Delta Dental.

Each time an Indemnity Dental claim is processed, you receive an Explanation of Benefits (EOB). The EOB explains when and where the dental services and supplies were provided. It also shows the amounts Delta Dental has paid and how much you must pay.

If you have questions about this explanation, call Delta Dental at (888) 335-8227.

-How to Appeal a Denied Delta Dental Claim

In some cases, you may not agree with the action taken regarding a claim. You may appeal the decision by writing to Delta Dental. You have up to 180 days after you receive your Explanation of Benefits or a denial of your claim to appeal the decision. Appeals should be sent directly to Delta Dental at the address printed on your EOB.

Remember to list your TBT Plan name (printed on the cover of your *Summary of Coverage*), your Social Security number and your telephone number. You should also include a copy of the treatment form or denial notice. Clearly explain why you think the decision is wrong.

Delta Dental representatives review and make a decision on your written appeal within 45 days of receipt. Some appeals may be referred to a dental consultant or the local dental society.

Delta Dental is regulated by the California Department of Corporations. The Department's Health Plan Division has a toll-free number (800) 400-0815 to receive complaints. However, if you have a grievance against Delta Dental, you should first call Delta Dental toll-free at (888) 335-8227 and use their grievance process before contacting the Health Plan Division.

If you would like to appeal Delta Dental's final decision to TBT's Board of Trustees, notify the TBT Plan Administration Office in writing within 180 days of receiving Delta Dental's written denial of your appeal. Your appeal should explain the issues, include Delta Dental's determination and any other relevant documents, and follow the steps explained on pages 40-43. You may not appeal to the Board of Trustees until you have already exhausted Delta Dental's appeal process.

Claim Payment Process

If you are enrolled in the Kaiser HMO or a pre-paid dental option 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, claims concerning eligibility and disability claims are subject to the procedures explained below.

Types of Claims

A claim is any request for Plan benefits made in keeping with the Plan's claims 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 to Your Benefits*. However, if you file a claim for benefits that is denied because you were not eligible for Plan coverage, that denial 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 dependent's);
- Patient's birth date;
- Your Social Security number;
- The date of service;
- The applicable "CPT-4" 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);
- 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 dependent.*

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 ten 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 42.*

Post-Service Claim: *Any claim other than a Pre-Service or Disability 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.
- *Hospital Admission 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 Life and Health at (800) 274-7767.

The TBT Plan Administration Office (and all of TBT's medical and dental 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 more time is required to process your claim because more information is needed 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 Disability Claims

If you become *totally disabled* and feel entitled to an extension of benefits (see page 9), you should send a claim and evidence of your disability to the TBT Plan Administration Office.

You will receive an initial decision on whether you qualify for a disability extension within 45 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; and for Indemnity Dental option claims, to Delta Dental.

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 will be 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 send 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 includes 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 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 also 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 timely provide in support of your appeal, even if they were not received or considered during the initial claim decision. The decision on your appeal will be made on the basis of the record, including any additional documents and comments you send.

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 and Disability 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 42 and 56.

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.

Claims and Appeals Timetable

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

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. If you or your covered dependents have

CLAIMS AND APPEALS TIMETABLE

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

Time Limits	TYPE OF CLAIM			
	Urgent Care Claim	Pre-Service Claim (non-urgent)	Post-Service Claim	Disability Claim
To make an initial claim determination	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days	45 days
Extension (if proper notice and delay is beyond Plan's control)	None	15 days	15 days	30 days (two 30-day extensions possible)
To request missing information from claimant	24 hours	5 days	30 days	45 days
For claimant to provide missing information	48 hours	45 days	45 days	45 days
For claimant to request appeal	180 days	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	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.

been overpaid by the Trust and 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 any of your eligible dependents 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. 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. The following rules determine which plan pays benefits first when benefits are coordinated:

1. A plan without a coordination of benefits provision or with a provision that bars or substantially obstructs coordination with this Plan is primary.
2. A plan covering a patient directly (for example, covering you as an *employee* rather than as someone's 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 dependent of a retiree.
4. If you or an eligible dependent are enrolled for COBRA coverage as a former participant in a TBT Plan, any group health plan covering you or an eligible dependent as an active employee will be primary. Your COBRA coverage from this Plan will be secondary.
5. If both you and your spouse are covered as active employees under a TBT Plan, your children may be enrolled for dependent coverage under both parents. However, the total benefit payments cannot be greater than 100% of the patient's actual covered expenses. The Plan will automatically coordinate the benefits in this case without need for double claim forms.
6. If a dependent child is covered by both parents' plans (and both parents are living in the same household), the plan of the parent whose birthday falls first in the year is primary. If only one plan includes this *birthday rule*, the plan without the rule pays first. If none of the preceding rules apply, the plan that has covered the patient the longest is primary.
7. When a dependent child is covered under two or more plans and the parents are legally separated, divorced or unmarried, the plan of the parent with custody is primary. If the parent with custody is remarried, the custodial parent's plan pays first, the stepparent's plan pays second and the plan of the parent without custody pays third.
8. For a child of legally separated or divorced parents, if there is a court decree setting forth a financial duty for the dependent child's medical expenses, the plan of the parent with that legal responsibility is primary. If rules 6, 7 or 8 do not apply, the plan that has covered the patient the longest is primary.

Regardless of whether this Plan is considered primary or secondary, if you or a dependent is (a) covered by the indemnity portion of this Plan, (b) have coverage under the Kaiser HMO (including any prepaid health coverage) under another group health plan and (c) incur expenses normally covered under the Kaiser HMO, then the Plan will only reimburse copayments required by the Kaiser HMO, and only if copayments are required of every person covered by the HMO.

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

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, this Plan will make additional payments only if the primary plan requires that you make a copayment. This Plan's payment will be 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 provider has agreed to accept contract rates. Therefore, total benefits paid by all plans should 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 will be paid. Contact the TBT Plan Administration Office if you are not sure how amounts will be coordinated.

HMO Coordination. If you join the Kaiser 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 materials provided by the Kaiser HMO for more information.

Coordination of Dental, Vision Care and Prescription Drug Payments. Dental, vision care and prescription drug coverage through TBT are 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.

Pre-Paid Dental Coordination. If you join a pre-paid dental plan and your covered dependents have dental coverage under a group plan, the group plan may not pay benefits if you choose a dental care provider that is not associated with the pre-paid dental plan.

Individual Plan Coordination. If you or your dependent (or both) are insured under an *individual* health plan or insurance program for which you pay premiums directly to the insurance company, this Plan will pay 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 or dental 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 Social Security Act*, as amended).

The Plan's Coordination of Benefit rules also include any plan that is required by law or by a no-fault vehicle plan to provide medical or dental payments which 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 will be considered to have received the benefits required by the law.

Coordination with Medicare. If you are an active employee covered by both Medicare (which refers to *Title XVIII of the Social Security Act*, as amended) and the Indemnity Medical option, your TBT Plan is primary for you and your covered dependents. This means that the Plan will determine its benefits without regard to whether you have coverage under Medicare and therefore most of your medical benefits will come from the Indemnity Medical option. The Plan will also be primary for your covered dependent if he or she is age 65 or older and covered by both the Indemnity Medical option and Medicare. *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.

Right to Recover Benefits

Teamsters Benefit Trust has 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 has the right to recover the amounts overpaid from you or from the benefit plan, insurance company, organization or provider to whom payment was made. If you or your covered dependent 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 has the right to make restitution to another plan that has overpaid, and this payment is considered a benefit under the Plan made on your behalf.

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 this provision, 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 any particular 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 related to how a claim is filed, 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 employee 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 an employee or dependent 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 either sue you to recover the amounts paid 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 dependent 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 dependent, legal representative or agent).
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 dependent, legal representative or agent) 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 dependent 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, 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.
8. To assign, upon the Plan's request, any right or cause of action to the Plan.

9. 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.
10. To cooperate in doing what is necessary to help the Plan recover the benefits paid or in pursuing any recovery.
11. 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
12. To the entry of judgment against you (and/or, if applicable, your dependent, legal representative, agent, trustee or trust fund) in any court for the amount of benefits paid on your or your dependent's 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 dependents 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 dependents 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 dependents' 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 or your dependents 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 dependents 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 dependents. 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 dependents.

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

Workers' Compensation

Workers' Compensation is a state-mandated benefit program that requires all employers to pay approved expenses connected with a work-related injury or illness.

Your TBT Plan does not replace or affect any requirement for coverage by Workers' Compensation. The Plan will not pay benefits for any accidental bodily injury caused by or occurring in the course of employment, or in connection with illness or injury for which you are entitled to benefits from Workers' Compensation or similar laws. However, the Plan may provide provisional coverage subject to a lien on any Workers' Compensation benefits that may be awarded. Such provisional coverage is subject to the terms and conditions described under *Recovering Benefits from a Third Party* on page 46.

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order or QMCSO is a child support order (determined by the Plan as qualified) that creates, recognizes or assigns a child's right to receive benefits as your covered dependent. (See page 60 for the Plan's full definition of a QMCSO.)

When the TBT Plan Administration Office receives a child support order for your child and determines that it is a QMCSO, the child is automatically enrolled as your eligible dependent. If the order is issued as a *National Medical Support Notice* that is determined by the Plan to be qualified, you and your child are automatically enrolled in the Medical option chosen by the applicable state's child support enforcement agency.

You may obtain without charge a copy of TBT's procedures governing *Qualified Medical Child Support Order* (QMCSO) determinations by contacting the TBT Plan Administration Office.

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 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 Agreements. 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 guide, 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
Secretary-Treasurer
Teamsters, Chauffeurs, Warehousemen and Helpers
Teamsters Local Union No. 490
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
Teamsters Automotive Employees
Teamsters Local Union No. 78
492 C Street
Hayward, CA 94541-5026

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
610 McKendrie Street
San Jose, CA 95110-1595

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 Information

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

Plan Administration

The Plan is administered by the joint Board of Trustees for TBT, which contracts with Lipman Insurance Administrators, Inc. for administrative services. You may write to the Board of Trustees at the following address:

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 *also* may be served on any member of the Board of Trustees.

Martin R. Lowy
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

All of the TBT Plans summarized in this guide are collectively bargained and jointly trusteed health and welfare plans that provide benefits for eligible participants and their covered dependents. The Teamsters Benefit Trust also provides disability and accidental death and dismemberment benefits for eligible participants only.

Plan Funding—Collective Bargaining Agreements

The Plan is primarily funded by monthly contributions from participating Employers paid on behalf of eligible employees and their covered dependents under a Collective Bargaining Agreement. You or your beneficiaries may receive from the TBT Plan Administration Office, upon written request, information as to whether a particular Employer or Union participates in the Plan and, if so, its address. Your Plan is maintained subject to the Collective Bargaining Agreements that provide 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 Employer contributions on your behalf. If your Employer stops making contributions to the Trust, your eligibility for benefits will end in keeping with Plan eligibility rules described on pages 1-6 of this guide. **Note:** Your TBT Plan may have additional eligibility provisions and Hour Bank rules that affect participation. See the *Supplement to the Plan VI Summary of Coverage (for Plans with Hour Bank Eligibility)* for the special provisions that may affect participation.

Contributions made by participating Employers are determined by the TBT Board of Trustees under the authority of the provisions set forth in the Collective Bargaining Agreements and *Trust Agreement*. In some cases, disabled employees may self-pay for a period of time when their Employer contributions end.

Plan Assets

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

Source and Funding of Benefits

Hospital and medical benefits are paid for directly by the Trust, unless you have enrolled for hospital and medical benefits with the Kaiser HMO, in which case TBT pays the Kaiser HMO monthly premiums and the Kaiser HMO funds the benefits. Prescription drug benefits are administered by Prescription Solutions and are paid directly by the Trust. Your TBT Plan requires Kaiser enrollees to use a Kaiser Pharmacy. Dental benefits in the Indemnity Dental option are administered by Delta Dental and are paid directly by the Trust. TBT pays the prepaid dental options' monthly premiums and benefits are funded through these organizations (currently Bright Now! Dental and Pacific Union Dental). Vision care benefits are administered by Vision Service Plan (VSP) and paid directly by the Trust. Life insurance and accidental death and dismemberment benefits are provided through an insurance policy with Prudential Life Insurance of America. Addresses for the Kaiser HMO, Prescription Solutions, Delta Dental, Bright Now! Dental/Newport Option, Pacific Union Dental and Prudential Life Insurance of America are listed on page 65. 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 Kaiser HMO are payable out of the Trust Fund and are limited to the availability of assets 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
October 1, 1982.

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 employees and retirees, their dependents and beneficiaries 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 pages 43-44).

Information About Taxes
The Plans described in this guide provide benefits to eligible employees 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 your Teamsters Benefit Trust Plan, you are entitled to certain rights and protection 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.

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 plan administrator may make a reasonable charge for the copies.

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. Continue health care coverage for yourself and eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents 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 pre-existing 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 health and 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 decisions 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 a 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or 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).

Retiree Benefits

The Teamsters Benefit Trust also provides benefits for eligible retired employees. These benefits are explained in a separate summary. Contact the TBT Plan Administration Office for more information.

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. A copy of the Plan's Privacy Notice is explained here.

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 54).

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:

- 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 the HMO 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 that was not expected and could not have been reasonably foreseen or avoided.

Accredited School or College. A high school, college or other *bona fide* educational institution such as a trade school that is accredited by the applicable authorities and provides a curriculum for full-time students.

Active Work. Performing the duties of your employment on a regular basis.

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 you will be provided upon request a copy 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 42-43).

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 Blue Shield National Network. The PPO network used by TBT for covered participants residing outside California.

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 page 18).

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 the Kaiser 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 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.

Children. Your unmarried sons and daughters (including stepchildren, legally adopted children or children for whom you and/or your spouse are the legally appointed guardian) who depend primarily on you for financial support, or a person for whom you are required to provide health coverage as the result of a Qualified Medical Child Support Order (QMCSO).

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/or 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 39-47.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law lets you and/or your covered dependents 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 contributions to the Plan on behalf of certain Employees and was approved by the Board of Trustees.

Convalescent Care Facility. (See *Skilled Nursing Facility or Convalescent Hospital* on page 60.)

Conversion Policy. An individual medical or life insurance policy that is *converted* from a TBT group policy when it ends.

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.

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 covered under the Kaiser 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. Copayments may also be charged under the pre-paid dental options.

Covered Expenses (under the Indemnity Dental option). The Usual, Customary and Reasonable (UCR) charges for necessary services performed by a dentist in the geographic area where you receive the dental care. Charges that Delta Dental considers to be higher than the UCR charges for a similar procedure in your geographical area are not covered.

Covered Expense (under the Indemnity Medical option). An expense for hospital, medical, surgical, prescription drug, dental, or vision care services or supplies provided by and not subject to any exclusions under the Plan.

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.

Covered Services (under the Indemnity Dental option). The specific dental service covered according to the administrative contract with Delta Dental.

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 dependents 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 or dental option.

Dentist. A doctor of dental surgery (D.D.S.) or a doctor of dental medicine (D.M.D.) licensed to practice dentistry in the state where treatment is provided.

Dependent. Eligible dependents include your legal spouse, your unmarried children under age 19 (or under age 26 if a *full-time student* based on Plan rules) and primarily dependent on you for financial support. (See pages 4-6 for rules related to a dependent child's eligibility as a full-time student.)

Disability, Total. A physical or mental condition for which you need a doctor's care and which prevents you from performing your regular duties as an employee or any employment for wages or profit, or prevents your covered dependent from doing the regular and customary activities for a person of the same age.

For You. The term means all periods of disability from the same condition. If you recover from this condition and return to active work that is covered by your TBT Plan for a period of at least two weeks, any later period of disability, even from the same condition, is considered a new disability.

For Your Covered Dependent. The term means all periods of disability from the same condition. If your dependent recovers and can resume the normal activities of a person in good health of the same age for a period of six months or longer, any later period of disability, even if it results from the same condition, is considered a new disability.

Disabilities caused by self-inflicted injuries, related to commission of a felony, or due to injury or illness related to military service, do not qualify as total disabilities.

Note: *To qualify under COBRA, a special definition of disability is required by federal law.* *See page 10 of this guide.*

Doctor. A physician or surgeon (M.D.) or a dentist 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 pages 2-4 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 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.

Employees. The common law employees of a participating Employer who are covered by TBT benefits under the terms of a Collective Bargaining Agreement or another written agreement.

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 on behalf of eligible employees.

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 is not recognized as conforming to safe and accepted medical or health practice,
- 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 and Indemnity Dental options, 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 (currently Kaiser) that covers only services and supplies received from HMO member providers and 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 the Kaiser HMO, see definition of hospice in the 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 Dental Option. Dental benefits provided by the Plan as described in this guide and your *Summary of Coverage*.

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 a covered person during a calendar year.

Maximum Lifetime Benefit. Total benefits payable for covered services or procedures for a covered person during his or her lifetime.

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 or dentist 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.

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, 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 and dental options once every 12 months. This is your Open Enrollment period. Each time you change an option, your new 12-month period begins. See *Open Enrollment—Changing Your Medical or Dental Option* on page 8.

Outpatient Surgical Procedures. Surgery ordinarily performed without overnight hospitalization.

Periodontics. Treatment of disease of the gums and tissues surrounding the teeth.

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

Physician. See definition of *Doctor*.

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 printed on the cover of your *Summary of Coverage*.

Postpartum Hospitalization. Hospitalization immediately following childbirth.

Pre-admission Certification. Approval through the Plan's Pre-admission Certification and Utilization Review Organization of a non-emergency hospitalization or surgery is required *in advance* of admission or treatment and within 72 hours of emergency hospitalization.

Preferred Provider Organization (PPO). Networks or groups of providers that the Indemnity Medical Option maintains through the Blue Cross Prudent Buyer program. (The PPO network does not apply to the Kaiser HMO options.)

PPO providers agree to accept pre-arranged rates for services (see *Blue Cross Prudent Buyer PPO Network* on page 56). 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 *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 currently selected by the TBT Board of Trustees to administer prescription drug benefits.

Preventive Dental Care. Under the Indemnity Dental option, prophylaxis, routine exams and other dental services listed on pages 29-30.

Preventive Medical Care. Under the Indemnity Medical option, routine physical exams and related x-rays and lab work, pap tests, routine mammograms, PSA tests for detection of prostate cancer, flu shots, routine pediatric exams and immunizations as recommended by the American College of Pediatrics.

Prophylaxis. The prevention of dental disease through cleaning, scaling and polishing of teeth.

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

Qualified Medical Child Support Order (QMCSO). A medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and that creates or recognizes the existence of a child's right (or assigns to a child the right) to receive benefits as a covered dependent of an eligible TBT Plan participant. The TBT Plan Administration Office must determine that the court order is qualified under the terms of ERISA and applicable state laws that create, recognize or assign the child's right to receive benefits as your covered dependent.

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 page 18).

Skilled Nursing Facility or Convalescent Hospital. 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 employee 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 Dental option). A *usual* fee is the amount that a dentist regularly charges and receives for a given service, or the fee actually charged, whichever is less. A *customary* fee is within the range of usual fees charged and received for a particular service by similarly trained dentists in the same geographic area. A *reasonable* fee is ordinarily what is usual and customary; but the Plan may conclude that a higher fee is justified for particular dental work that requires an extraordinary level of complexity.

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 rates. If your doctor or dentist 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. 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.

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.

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 TBT Plan named in your *Summary of Coverage*. 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 4:00 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 4:00 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 Kaiser HMO), marital status and dependent changes, contributions, Blue Cross ID cards, prescription drug ID cards, Indemnity Medical option claims, vision, disability, life and accidental death & dismemberment claims and other questions.
Blue Cross Life and Health	(800) 274-7767	21555 Oxnard Street Woodland Hills, CA 91367	Hospital Pre-admission Certification and Utilization Review.
Blue Cross Prudent Buyer PPO Network www.bluecrossca.com	(888) 887-3725	21555 Oxnard Street Woodland Hills, CA 91367	Preferred Provider hospitals, PPO Network physicians and other PPO providers.
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.*
Kaiser Member Services www.kaiserpermanente.org	(800) 464-4000	1800 Harrison, 9th Floor Oakland, CA 94612-2998	HMO benefit questions.*
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.
Delta Dental www.deltadentalca.org	(800) 765-6003 or (888) 335-8227	P.O. Box 7736 San Francisco, CA 94120-7736	Dental Option 1 benefit questions.* For Delta Dental provider finder service, call (800) 427-3237.
Bright Now! Dental/ Newport Option	(800) 497-6453 (714) 668-1300	201 E. Sandpointe, #200 Santa Ana, CA 92707	Dental Option 2 benefit questions.*
Pacific Union Dental (PUD)	(800) 999-3367	1390 Willow Pass Road, #800 Concord, CA 94520-5240	Dental Option 3 benefit questions.*
Vision Service Plan (VSP)	(800) 877-7195	P.O. Box 997100 Sacramento, CA 95899-0001	Vision benefit questions.*
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.
Prudential Life Insurance	(800) 524-0542	P.O. Box 1215 Newark, NJ 07101-1215	First call the TBT Plan Administration Office.

***Note:** For general enrollment information, medical and dental option elections, address changes and changes in dependent status, contact the TBT Plan Administration Office. Any required forms (including medical and dental option change forms) are mailed to you by TBT.*

NOTES