

T E A M S T E R S   B E N E F I T   T R U S T

# COMPARISON OF MEDICAL BENEFITS

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# COMPARISON OF MEDICAL BENEFITS—PLAN IV

**SUMMARY:** This brochure provides a brief summary of medical benefits offered by each medical option. For a full Plan description, refer to the specific Plan materials (*Guide to Your Benefits, Summary of Coverage, Plan Change Notices, Summary of Material Modifications* or HMO disclosure information).

**HMO:** An HMO is a Health Maintenance Organization. Your Plan offers Kaiser and United HealthCare HMOs. Refer to each HMO's *Evidence of Coverage* for details and enrollment requirements.

**PPO:** A PPO is a Preferred Provider Organization (hospital, physician or other provider) belonging to the Anthem Blue Cross PPO network. A non-PPO is a provider that does not belong to the Anthem Blue Cross PPO network. PPO claims are paid based on contract rates. All non-PPO claims are paid based on Usual, Customary and Reasonable (UCR) charges that are usually higher than the PPO contract rates (resulting in higher out-of-pocket expenses). Your *Summary of Coverage* shows the difference between PPO and non-PPO coverage under Your Plan. Covered persons are responsible for being treated by PPO providers to reduce out-of-pocket costs. Since participating providers change often, check that a doctor or hospital is a PPO provider before receiving services by calling Anthem Blue Cross toll-free at (888) 887-3725. Call (800) 810-2583 for providers outside of California.

**UCR:** All non-PPO claims are paid based on Usual, Customary and Reasonable (UCR) charges (see PPO above).

**Anthem Blue Cross:** Notify Anthem Blue Cross at (800) 274-7767 in advance of a non-emergency hospital stay and within 72 hours of an emergency admission.

**TAP:** Teamsters Assistance Program (TAP) must oversee and pre-approve all alcohol and drug dependency treatment. Call (800) 253-TEAM or (510) 562-3600.

		<b>SELF-FUNDED OPTION INDEMNITY MEDICAL PLAN</b>
<b>MEDICAL BENEFITS</b>	Calendar year maximum Deductible per calendar year: Per covered person Family maximum <i>Note: All medical benefits except chiropractic, TAP and outpatient prescription drugs (or where noted) are subject to deductible.</i>	<b>\$2,000,000</b>  <b>\$100</b> <b>\$300</b>
<b>HOSPITAL</b> <i>Note: Non-emergency use of hospital emergency rooms on weekdays or during daytime hours will be paid at 50% of PPO rate or 50% of UCR if non-PPO (except with advance request of patient's regular doctor).</i>	INPATIENT (Subject to deductible): PPO Non-PPO <i>Note: Under the Indemnity Medical option, all in-hospital care must be pre-authorized and monitored by the Plan's Review Organization. In an emergency, call within 72 hours.</i> OUTPATIENT (Subject to deductible): PPO Non-PPO Exception: Surgery or accident within 24 hours with no deductible	<b>100%</b> <b>50% of UCR</b>  <b>80% to \$5,000 per calendar year; 100% thereafter</b> <b>100% of UCR thereafter</b> <b>100% of PPO or UCR</b>
<b>ACCIDENT EXPENSE BENEFIT</b>	PPO Non-PPO First \$300 not subject to deductible. Treatment within 3 months of accident.	<b>100% to \$300</b> <b>100% of UCR to \$300</b>
<b>AMBULANCE</b>	PPO Non-PPO	<b>100%</b> <b>80% of UCR to \$5,000 per calendar year; 100% of UCR thereafter</b>
<b>SURGERY PHYSICIAN SERVICES</b>	PPO Non-PPO	<b>100%</b> <b>80% of UCR to \$5,000 per calendar year; 100% of UCR thereafter</b>
<b>DOCTOR VISITS</b>	PPO Non-PPO	<b>100%</b> <b>80% of UCR to \$5,000 per calendar year; 100% of UCR thereafter</b>
<b>PREVENTIVE CARE</b>	<i>Routine physical exams and related x-ray and lab work, pap tests, routine mammograms (see Diagnostic X-ray and Lab below), PSA tests for detection of prostate cancer, flu shots, routine pediatric exams and shots recommended by the U.S. Preventive Services TaskForce.</i> Calendar year maximum PPO Non-PPO	<b>None</b> <b>100%</b> <b>90% of UCR</b>
<b>DIAGNOSTIC X-RAY AND LAB</b>	PPO Non-PPO <i>Note: Mammograms follow American Cancer Society guidelines. Routine mammograms are covered annually beginning at age 40.</i>	<b>100%</b> <b>80% of UCR to \$5,000 per calendar year; 100% of UCR thereafter</b>
<b>NURSING HOME CARE</b>	Per disability maximum Room and board (within seven days of in-hospital stay of five or more days) PPO Non-PPO	<b>60 days</b>  <b>100%</b> <b>80% of UCR to \$5,000 per calendar year; 100% of UCR thereafter</b>
<b>MENTAL HEALTH SERVICES IN HOSPITAL</b>	Calendar year maximum PPO Non-PPO	<b>30 days</b> <b>100%</b> <b>50% of UCR</b>
<b>MENTAL HEALTH SERVICES IN MEDICAL OFFICES</b>	Outpatient mental health and nervous disorder benefit: Per visit covered expense maximum PPO Non-PPO	<b>\$80</b> <b>100%</b> <b>80% of UCR</b>
<b>TREATMENT FOR ALCOHOL AND CHEMICAL DEPENDENCY</b>	Maximum treatments per lifetime Maximum covered expenses per treatment First treatment—TAP-approved Second treatment—TAP-approved <i>Note: The 20% copayment owed for a second treatment at a pre-approved TAP facility is not a covered expense and will not apply toward the hospital copayment maximum for the calendar year.</i>	<b>Two</b> <b>None</b> <b>100%</b> <b>80%</b>
<b>CHIROPRACTIC (Not Subject to Deductible)</b>	<i>Initial visit and diagnostic x-rays do not count against the maximums below and are subject to the deductible:</i> PPO Non-PPO Per visit maximum Calendar year maximum <i>Note: Separate \$300 calendar year maximum for muscle spasms, soft tissue or back strain.</i>	<b>100% up to \$25</b> <b>100% of UCR up to \$25</b> <b>\$25</b> <b>\$1,250</b>
<b>PRESCRIPTION DRUGS—OUTPATIENT</b>	Using OptumRx plastic ID card: Generic drugs from OptumRx pharmacies <i>Note: If you or your doctor order a brand name drug when a generic is available, you also pay the cost difference between generic and brand name.</i> Outpatient drugs at non-participating pharmacies Direct reimbursement by OptumRx. Amount reimbursed is usually less than retail charges at a non-participating pharmacy. <i>Mail Service Program: For information regarding mail service benefits and injectable medications, see your Plan's Summary of Coverage.</i>	<b>80%</b>
<b>MEDICAL COPAYMENT LIMIT (per calendar year)</b>	<b>PPO claims</b> <b>Non-PPO claims</b>	<b>80% of PPO to \$5,000; 100% over \$5,000</b> <b>80% of UCR to \$5,000; 100% of UCR over \$5,000</b>

# TEAMSTERS BENEFIT TRUST (TBT)

## HMO OPTIONS

### KAISER

### UNITED HEALTHCARE

Calendar year maximum Deductible per calendar year Copayments apply to specified services	<b>none</b> <b>none</b>	Calendar year maximum Deductible per calendar year Copayments apply to specified services	<b>none</b> <b>none</b>
Physician and surgeon services Intensive care/cardiac care Room and board Laboratory and x-ray Physical therapy Administered medications Other necessary services and supplies Emergency room ( <i>Note: Waived if admitted to hospital</i> )	<b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b>	Physician and surgeon services Intensive care/cardiac care Room and board Laboratory and x-ray Physical therapy Administered medications Other necessary services and supplies Emergency room	<b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>\$35</b>
No similar benefit		No similar benefit	
Within Kaiser's service area when approved by a Kaiser physician	<b>no charge</b>	In connection with an authorized confinement/valid emergency	<b>no charge</b>
Physician and surgeon services	<b>no charge</b>	Physician and surgeon services	<b>no charge</b>
Office visits, check-ups, exams, OB/GYN Hearing and vision exams Physical therapy visits Allergy test injection visits Administered medications, injections Laboratory and x-ray	<b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b>	Office visits, check-ups, exams, OB/GYN Hearing and vision exams Physical therapy visits Allergy test injection visits Administered medications, injections Laboratory and x-ray	<b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b> <b>no charge</b>
Similar preventive care	<b>no charge</b>	Similar preventive care	<b>no charge</b>
Laboratory, x-ray and other tests	<b>no charge</b>	Laboratory, x-ray and other tests	<b>no charge</b>
Skilled nursing facility care at authorized facility	<b>no charge up to 100 days per benefit period</b>	Skilled nursing care at authorized facility	<b>no charge up to 100 consecutive days from the first treatment per disability</b>
In-hospital care	<b>no charge</b>	In-hospital care Severe mental health illness benefits	<b>no charge up to 30 days per calendar year unlimited days</b>
Individual care Group therapy	<b>no charge</b> <b>no charge</b>	Outpatient care Severe mental health illness benefits See the <i>Supplement to the United HealthCare Combined Evidence of Coverage Disclosure Form</i> for details.	<b>no charge up to 30 visits per calendar year unlimited visits</b>
Treatment, including counseling for dependency and medical management of withdrawal symptoms, is provided in medical offices in group or individual sessions at minor charge. Hospitalization provided at no charge for detox only. <i>Indemnity Medical option benefits also payable. See Kaiser Evidence of Coverage and Disclosure Form.</i>		Hospitalization provided at no charge for detox only. See United HealthCare <i>Evidence of Coverage and Disclosure form. Indemnity Medical option benefits also payable.</i>	
Not covered See Kaiser <i>Evidence of Coverage and Disclosure form.</i>		Not covered See United HealthCare <i>Evidence of Coverage and Disclosure form.</i>	
<i>Covered under the Indemnity Medical option (see page 2).</i>		<i>Covered under the Indemnity Medical option (see page 2).</i>	

# COMPARISON OF MEDICAL BENEFITS—PLAN IV (Continued)

	SELF-FUNDED OPTION INDEMNITY MEDICAL PLAN	HMO OPTIONS	
		KAISER	UNITED HEALTHCARE
<b>TELEPHONE NUMBERS FOR ADDITIONAL INFORMATION</b>	<p>TBT Plan Administration Office: <b>(510) 796-4676</b> <b>(800) 533-0119</b></p> <p>Anthem Blue Cross—for current PPO hospital and physician information: <b>(888) 887-3725</b></p> <p>Anthem Blue Cross—for <i>required</i> Pre-admission Certification of <i>non-emergency</i> hospital confinements: <b>(800) 274-7767</b></p> <p>Teamsters Assistance Program (TAP) <b>(800) 253-TEAM</b> <b>(510) 562-3600</b></p>	<p><b>(800) 464-4000</b> Refer to the HMO's <i>Evidence of Coverage</i> for details and enrollment requirements.</p>	<p><b>(800) 624-8822</b> Refer to the HMO's <i>Evidence of Coverage</i> for details and enrollment requirements.</p>
<b>SERVICE AREA</b>	No geographic limitations	<p>The service area of this Plan is the geographical area within a 30-mile radius of any Kaiser Permanente medical facility in the following counties:</p> <p><b>Alameda</b> <b>Amador</b> <b>Contra Costa</b> <b>El Dorado</b> <b>Fresno</b> <b>Imperial</b> <b>Kern</b> <b>Kings</b> <b>Los Angeles</b> <b>Madera</b> <b>Marin</b> <b>Mariposa</b> <b>Napa</b> <b>Orange</b> <b>Placer</b> <b>Riverside</b> <b>Sacramento</b> <b>San Bernardino</b> <b>San Diego</b> <b>San Francisco</b> <b>San Joaquin</b> <b>San Mateo</b> <b>Santa Clara</b> <b>Solano</b> <b>Sonoma</b> <b>Stanislaus</b> <b>Sutter</b> <b>Tulare</b> <b>Ventura</b> <b>Yolo</b> <b>Yuba</b></p> <p>For information about services available where you live, contact Membership Services toll-free at (800) 464-4000.</p>	<p>United HealthCare is offered in the following counties:</p> <p><b>Alameda</b> <b>Contra Costa</b> <b>El Dorado</b> <b>Fresno</b> <b>Imperial*</b> <b>Kern</b> <b>Kings</b> <b>Los Angeles</b> <b>Madera*</b> <b>Marin</b> <b>Merced</b> <b>Nevada</b> <b>Orange</b> <b>Placer*</b> <b>Riverside</b> <b>Sacramento</b> <b>San Bernardino*</b> <b>San Diego</b> <b>San Francisco</b> <b>San Joaquin</b> <b>San Luis Obispo</b> <b>San Mateo</b> <b>Santa Barbara</b> <b>Santa Clara</b> <b>Santa Cruz</b> <b>Solano</b> <b>Sonoma</b> <b>Stanislaus</b> <b>Tulare</b> <b>Ventura</b> <b>Yolo</b></p> <p>* Only portions of these counties are within the United HealthCare service areas.</p>
<b>Open Enrollment</b> You can change your TBT medical and dental options once a year. Open Enrollment takes place from January 1 through December 31. After your initial election of medical and dental options, you may change them once every 12 months. Contact the TBT Plan Administration Office for details.			

This **Comparison of Medical Benefits** is only a summary of the coverage actually provided by each of the above-specified programs. All exclusions and limitations of benefit coverage have not been listed and may vary by TBT Plan. The contents of this comparison are not to be construed or accepted as a substitute for the provisions of the Rules and Regulations of the Teamsters Benefit Trust or the contracts with Kaiser or United HealthCare, which control in case of conflict. See each HMO's Evidence of Coverage and Disclosure form for the most current details. To maintain the financial stability of the Plan, the Trustees must reserve the right to change the benefits, deductibles or copayments or to terminate the Plan at any time.