TEAMSTERS BENEFIT TRUST

COMPARISON OF MEDICAL BENEFITS

PLAN VI

REVISED SEPTEMBER 2012

COMPARISON OF MEDICAL BENEFITS—PLAN VI

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. Under Plan VI, TBT offers Kaiser for the HMO option. Refer to the 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 Blue Cross Prudent Buyer network. A non-PPO is a provider that does not belong to the Blue Cross Prudent Buyer 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 Plan VI. Covered persons are responsible for using 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 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).

Blue Cross Life and Health: Notify Blue Cross Life and Health 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.

	SELF-FUNDED OPTION INDEMNITY MEDICAL PLAN
MEDICAL BENEFITS ***Carryover: Any part of the deductible satisfied in the last three calendar months will also apply to next calendar year deductible.***	Calendar year maximum (combined medical/prescription drug) ***$2,000,000*** Calendar year deductible (combined medical/prescription drug): Per covered person—PPO ***$250*** Per covered person—Non-PPO ***$500*** Family maximum—PPO ***$500*** Family maximum—Non-PPO ***$1,000***
HOSPITAL ***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 hour***	INPATIENT PPO (Not subject to deductible) ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO (Subject to deductible) ***50% of UCR*** OUTPATIENT (Subject to deductible): PPO (Subject to deductible) ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO (Subject to deductible) ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
AMBULANCE	PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
SURGERY PHYSICIAN SERVICES	PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
DOCTOR VISITS	INPATIENT PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter*** OUTPATIENT PPO (after $10 copayment) ***100%*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
PREVENTIVE CARE	*Routine physical exams and related x-ray and lab work, pap tests, routine mammograms, PSA tests for detection of prostate cancer, flu shots and routine pediatric exams and shots as recommended by the U.S. Preventive Services TaskForce.* Calendar year maximum ***$250*** Two-year maximum ***$500*** PPO (after $10 copayment) ***100% to $250*** Non-PPO ***80% of UCR to $250*** Exam only ***100% of UCR to $250***
DIAGNOSTIC X-RAY AND LAB	PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter*** ***Note:*** *Mammograms follow American Cancer Society guidelines. Routine mammograms are covered annually beginning at age 40.*
NURSING HOME CARE	Room and board (within seven days of in-hospital stay of five or more days) Per disability maximum ***60 days*** PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***80% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
MENTAL HEALTH SERVICES IN HOSPITAL	Calendar year maximum ***30 days*** Lifetime maximum ***60 days*** PPO (Not subject to deductible) ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO (Subject to deductible) ***50% of UCR***
MENTAL HEALTH SERVICES IN MEDICAL OFFICES	Outpatient mental health and nervous disorder benefit ***Up to 20 Visits/Calendar Year*** PPO ***50% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
TREATMENT FOR ALCOHOL AND CHEMICAL DEPENDENCY ***(Not subject to deductible)***	Maximum treatments per lifetime ***Two*** Maximum covered expenses per treatment ***None*** First treatment—TAP approved ***100%*** Second treatment—TAP approved ***80%*** *Note: The 20% copayment for second treatment is not a covered expense and will not apply toward your copayment maximum for the calendar year.*
CHIROPRACTIC	PPO ***80% to $15,000 per calendar year; 100% thereafter*** Non-PPO ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter***
PRESCRIPTION DRUGS —OUTPATIENT	Purchased through Prescription Solutions OptumRx provider and reimbursed through TBT Plan Administration Office (after medical/prescription drug deductible is met) as follows: Drugs from Prescription Solutions pharmacy (reimbursed by TBT) ***80% to $15,000 per calendar year; 100% thereafter*** *Note: If you (or your doctor) order a brand name drug (when a generic equivalent is available), you also pay the difference between generic and brand name.* Outpatient drugs from non-Prescription Solutions pharmacy (reimbursed by TBT Plan Administration Office) ***50% of UCR to $15,000 per calendar year; 100% of UCR thereafter*** ***Mail Service:*** *Prescriptions ordered through the Prescription Solutions Mail Service Program (100-day supply). After the first two prescriptions/refills are ordered through retail, future refills must be ordered through mail service.* ***Specialty Pharmacy Program:*** *Prescriptions ordered through the Prescription Solutions Mail Service Program (100-day supply). After the first two prescriptions/refills are ordered through retail, future refills must be ordered through mail service.*

HMO OPTION—KAISER

Benefit	Details
Lifetime maximum **none** Calendar year deductible **none** Covered expense maximum Per covered person **$1,500** Family **$3,000** Copayments applied to specific services	If you choose the Kaiser HMO, you must live within the HMO service area to enroll (see the list on the next page). Out-of-area benefits are available for emergency only. For the most current details, call the Kaiser customer service number printed on the back page or visit their web site at *www.kaiserpermanente.org*.
Physician and surgeon services **no charge** Intensive care/cardiac care **no charge** Room and board **no charge** Laboratory and x-ray **no charge** Physical therapy **no charge** Administered medications **no charge** Other necessary services and supplies **no charge** Durable medical equipment **no charge** Emergency room *(Note: Waived if admitted to hospital)* **$50 copayment**	See Kaiser *Evidence of Coverage and Disclosure* form.
Within Kaiser's service area when approved by a Kaiser physician **no charge**	See Kaiser *Evidence of Coverage and Disclosure* form.
Physician and surgeon services **no charge**	See Kaiser *Evidence of Coverage and Disclosure* form.
Office visits, check-ups, exams, OB/GYN **$20/visit** Hearing and vision exams **$20/visit** Physical therapy visits **$20/visit** Allergy test injection visits **$20/visit** Administered medications, injections **no charge** Laboratory and x-ray **no charge**	See Kaiser *Evidence of Coverage and Disclosure* form.
Similar preventive care **$20 copayment**	See Kaiser *Evidence of Coverage and Disclosure* form.
Laboratory, x-ray and other tests **no charge**	See Kaiser *Evidence of Coverage and Disclosure* form.
Skilled nursing facility care at authorized facility **no charge up to 100 days**	See Kaiser *Evidence of Coverage and Disclosure* form.
In-hospital care **no charge up to 45 days per calendar year**	*Note: The following are covered with no separate limits for days or visits: Schizophrenia, schizo-affective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, bulimia nervosa and clinically-defined serious emotional disturbances of children.*
Maximum visits per calendar year **20** Individual care **$20/visit** Group therapy **$10/visit**	See Kaiser *Evidence of Coverage and Disclosure* form.
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.	*Indemnity Medical option benefits also payable.* *See Kaiser Evidence of Coverage and Disclosure Form.*
Not covered	See Kaiser *Evidence of Coverage and Disclosure* form.
Up to 100-day supply. If you are enrolled in the Kaiser Medical Option, your prescriptions must be filled at a Kaiser facility pharmacy or mail service. You must also use their drug formulary's list of approved medications for their pharmacy in your service area.	See Kaiser *Evidence of Coverage and Disclosure* form.

COMPARISON OF MEDICAL BENEFITS—PLAN VI *(Continued)*

	SELF-FUNDED OPTION INDEMNITY MEDICAL PLAN	HMO OPTION—KAISER
TELEPHONE NUMBERS FOR ADDITIONAL INFORMATION	TBT Plan Administration Office: ***(510) 796-4676*** ***(800) 533-0119*** Blue Cross Prudent Buyer Plan—for current PPO hospital and physician information: ***(888) 887-3725*** Blue Cross Life and Health—for *required* Pre-admission Certification of *non-emergency* hospital confinements: ***(800) 274-7767*** Teamsters Assistance Program (TAP) ***(800) 253-TEAM*** ***(510) 562-3600***	***(800) 464-4000***
SERVICE AREA	No geographic limitations	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: ***Alameda*** ***Amador*** ***Contra Costa*** ***El Dorado*** ***Fresno*** ***Imperial*** ***Kern*** ***Los Angeles*** ***Kings*** ***Madera*** ***Marin*** ***Mariposa*** ***Napa*** ***Orange*** ***Placer*** ***Riverside*** ***Sacramento*** ***San Bernardino*** ***San Diego*** ***San Francisco*** ***San Joaquin*** ***San Mateo*** ***Santa Clara*** ***Solano*** ***Sonoma*** ***Stanislaus*** ***Sutter*** ***Tulare*** ***Ventura*** ***Yolo*** ***Yuba*** For information about services available where you live, contact Membership Services toll-free at (800) 464-4000.

This ***Comparison of Medical Benefits*** *is only a summary of the coverage actually provided by each of the 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, which control in case of conflict. See the 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.*