TEAMSTERS BENEFIT TRUST

# GUIDE TO YOUR BENEFITS

GRANDFATHERED PLANS I, I-85, I-A, III, III-A, IV, V AND V-A


REVISED JULY 2023

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# Teamsters Benefit Trust (TBT)

## Board of Trustees

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

The current Trustees are listed on page 71 and in your *Summary of Coverage*. The most recent list may be found at www.tbtfund.org. The Board of Trustees has sole authority to interpret Plan provisions and 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 reserves the authority to amend or terminate the Plan at any time.***

If you wish, you may write to the Board of Trustees in care of the TBT Plan Administration Office at the address on this page.

## 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**

### *Office Address*

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

### *Website*

www.tbtfund.org

### *Office Hours*

8:00 a.m. to 5:00 p.m. PT
Monday-Friday (except holidays)

### *Phone Hours—Customer Service*

8:30 a.m. to 4:30 p.m. PT
Monday-Friday (except holidays)
(510) 796-4676 or (800) 533-0119
TTY/TDD/TT: 711

### *Fax Number*

(510) 795-0680
**Do not send Claims by fax** unless the TBT Plan Administration Office requests that you do so.

### *For General Emails Only*

- info@tbtfund.org

### *For Claims Inquiries and Appeals Only*

- Email: eobinquiry@titan-tpa.com
- Fax: (510) 795-0738

# Introduction

This *Guide to Your Benefits* for "Grandfathered" Plans 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 Teamsters Benefit Trust (TBT) Plan. **Note:** "Grandfathered" means that the Plans covered by this *Guide* are considered "grandfathered plans" under the Affordable Care Act of 2010.

***IMPORTANT WORDS***

*Throughout this **Guide**, some words are capitalized because they have specific meanings. These words are explained in the Definitions section beginning on page 80.*

## Summary Plan Description

This *Guide* along with the *Summary of Coverage* and *Comparison of Medical Benefits* (all contained in the blue folder with the heading *Your Benefits Package*) is technically known as a *Summary Plan Description*.

This *Summary Plan Description* (SPD) is the primary "plan document" under the Employee Retirement Income Security Act of 1974 (ERISA). There is not a separate "plan document."

If you choose medical coverage through an HMO, such as Kaiser, the HMO's *Evidence of Coverage* will also serve as a plan document describing your benefits. An enrollment and information packet is sent to you containing the HMO's *Evidence of Coverage*.

Together, these SPD materials provide the information you need to use your TBT Plan (referred to in this *Guide* as the "Plan" and "your TBT Plan").

A Trust Agreement, Collective Bargaining Agreements and Internal Revenue Service and Department of Labor regulations are also used to determine how the Plan operates, what benefits are paid and who is eligible to receive them.

*For Plans that have Hour Bank provisions, eligible participants are sent a **Supplement to the Guide to Your Benefits for Plans with Hour Bank Eligibility**. The supplement explains how the Plan participation and eligibility provisions are different under the Hour Bank Plan.*

When changes are made to the Plan, you will be sent a *Plan Change Notice* or written update (officially known as a *Summary of Material Modifications*). Be sure to read these notices and keep them in the folder pocket with your other Plan materials.

**Note:** These notices are also posted on the TBT website at www.tbtfund.org.

Information about Plan administration and your legal rights under ERISA is found in the section starting on page 71.

Refer to your *Summary of Coverage* for other details you need to know (such as your Plan name and amounts of any Deductibles, Copayments, Coinsurance percentages, benefit maximums and Allowed Amounts).

If you have questions, contact the TBT Plan Administration Office at the numbers shown on page 1.

**Note:** Your eligibility or right to benefits under the Plan should not be interpreted as a guarantee of employment. No individual shall have accrued or vested rights to benefits under the Plan.

***This Summary Plan Description is not a guaranty of eligibility or benefits.***

## Nondiscrimination Statement

TBT complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

TBT:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic and other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact TBT's Quality Assurance Manager at (800) 533-0119.

If you believe that TBT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, or electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 868-1019; (800) 537-7697
TTY/TDD/TT: (800) 537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

***ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-462-8641.***

注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *866-462-8641*.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *866-462-8641*.

*PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wikanang walang bayad. Tumawag sa 866-462-8641.*

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *866-462-8641* 번으로 전화해 주십시오.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما.بگیرید تماس با. باشد می ف *866-462-8641*

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝
Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *866-462-8641* (հեռատիպ).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *866-462-8641*.

注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。*866-462-8641* まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *866-462-8641:* والبكم الصم

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸ~ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ~ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। *866-462-8641* 'ਤੇ ਕਾਲ ਕਰੋ।

## 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 page 1.

### *Office Hours*

8:00 a.m. to 5:00 p.m. PT, Monday through Friday (except holidays).

### *Customer Service Hours*

8:30 a.m. to 4:30 p.m. PT, 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 más información comuníquese con la Oficina de Administración del Plan TBT a la dirección que se encuentra en la página uno.

### *Horas de Oficina*

8:00 a.m. a 5:00 p.m. PT, Lunes a Viernes (excepto días feriados).

### *Horas de Servicio al Cliente*

8:30 a.m. a 4:30 p.m. PT, Lunes a Viernes (excepto días feriados). El número de teléfono es **(510) 796-4676** o **(800) 533-0119**.

# Eligibility and Enrollment

### Special Eligibility Provisions

Some TBT Plans have additional eligibility provisions that affect participation. Check your Plan's *Summary of Coverage*, the *Supplement to the Guide to Your Benefits for Plans with Hour Bank Eligibility* and your Collective Bargaining Agreement for any provisions that may affect participation in your TBT Plan.

### Plan Participation

To participate in the Plan, you must work for an Employer who is obligated under a Collective Bargaining Agreement or participation agreement to make contributions to the Plan on your behalf. If your Employer stops making contributions to the Plan on your behalf, you will no longer be eligible for benefits. (See *COBRA Continuation Coverage Provided* on page 17 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 on your behalf.

***Example #1.*** *Assume your Employer's new Collective Bargaining Agreement provides for participation in TBT starting in January and requires your Employer to contribute for any Employee who worked 80 hours or more in the prior month—here 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, when you start work, your Employer is already participating in TBT, your coverage begins on the first day of the month after the second 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 each of these 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 July and September for your Employer to be required to make the required Plan contributions on your behalf for both of those months. Your coverage begins on October 1—as long as all required enrollment forms are received. If you work the minimum required hours two months in a row (in April and May), you become eligible for benefits on June 1—as long as the required contributions are paid and your enrollment forms are received by the TBT Plan Administration Office.*

#### RETURN ALL REQUIRED FORMS

*All required enrollment forms—including the TBT Enrollment Form, Medical Option Form, Dental Option Form (and an HMO application if you choose an HMO)—must be received by the TBT Plan Administration Office before your medical and dental coverage begins. (See* ***How to Enroll*** *on page 7.)*

## DEPENDENT COVERAGE

### Who is Eligible for Coverage as your Dependent?

Dependents eligible for coverage in your TBT Plan include your:

- Legal Spouse.
- Domestic Partner.
- Eligible Children (as explained on pages 4-6).

### When Dependent Coverage Begins

Coverage begins for your covered Dependents at the same time as yours does—as long as (1) you satisfy the eligibility requirements for Active participants described in this *Guide*, and (2) your Employer makes the required contributions, and (3) the TBT Plan Administration Office receives your completed enrollment forms within 30 days of your eligibility date (as explained in this *Guide*).

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 certificate or court order may be required, depending on the circumstances (as explained on page 7).

### *Dependent Enrollment Steps*

1. Call 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 under the Indemnity Medical Option—or perhaps denied if you are enrolled in an HMO. HMOs have specific requirements for adding or removing Dependents. (See the HMO's enrollment materials for information about enrolling a Dependent.)
2. Once TBT is notified, all required forms will be mailed to you (as explained in *How to Enroll* on page 7).

   **Remember, coverage does not begin until after the TBT Plan Administration Office receives your completed enrollment forms (and any other required documents).**
3. When TBT receives your completed enrollment forms, your effective date of coverage will be retroactive to the first date of eligibility unless (1) you are enrolled in an HMO and the HMO does not permit retroactive enrollment, or (2) TBT would be materially harmed because of the delay in enrollment. (For example, a Claim otherwise eligible for stop-loss reinsurance is ineligible for reimbursement because of the late enrollment.)

**Important Note:** If you do not enroll your Dependents **within 30 days of eligibility**, your Dependents' coverage will ***not*** be retroactive to your first date of eligibility but will begin the month following the month when the TBT Plan Administration Office receives the Dependents' enrollment information.

## 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 an HMO. (See *How to Enroll* on page 7.)

## Domestic Partnership Coverage

Domestic Partners are defined as two adults of any age who are registered as Domestic Partners with any state or local government agency authorized to perform such registrations. The requirements for proof of relationship or waiting periods are *the same* as applied to married couples.

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 Form* as taxable income and to pay all Employer payroll taxes for such amount. Or, alternatively, your Employer must 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 making that determination. Upon request, the TBT Plan Administration Office will provide a form for this purpose. (For more information, see *Tax Consequences of Domestic Partner Eligibility* on this page.)

## 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. 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 Partnership 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 taxes related to your Domestic Partnership 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.

## Who is Eligible as a Dependent Child?

Children include your:

- Son and daughter.
- Stepchild.
- Legally adopted child.
- Child placed with you for adoption.
- Child for whom you and/or your Spouse are the legally appointed guardian.
- Child of your Domestic Partner.
- Person for whom you are required to provide Dependent health coverage as the result of a Qualified Medical Child Support Order (*QMCSO)*, defined on page 85.

## Children Covered until Age 26

Your eligible Children are covered until age 26 regardless of whether they are married, dependent on you for financial support, living with you or enrolled in school. Coverage ends at the end of the month when they reach their 26th birthday.

## Coverage for Adult Disabled Children

Your TBT Plan will cover Children ages 26 and older who cannot earn a living due to a mental or physical disability that existed prior to reaching age 19. The TBT Plan Administration Office will provide you with specific guidelines to determine whether the child qualifies as disabled under the Plan. You will need to complete the *Disabled Dependent Application and Covered Employee Questionnaire* to apply for disabled Dependent coverage. Your Doctor must also complete the special certification forms that verify how a physical or mental disability prevents the Dependent from doing the regular and customary activities for a person of the same age and describe any other mitigating factors contributing to the disability.

## Dependent Social Security Numbers Needed

To comply with federal Medicare Coordination of Benefits regulations and certain IRS reporting rules, you must promptly provide to the TBT Plan Administration Office the Social Security number (SSN) of your eligible Dependents for whom you have elected (or are electing) Plan coverage and information on whether you or any such Dependents are currently enrolled in Medicare or have disenrolled from Medicare.

This information will be requested when you first enroll for Plan coverage but may also be requested later. If a Dependent does not yet have a Social Security number, you can go to this website to complete a form to request the SSN: www.socialsecurity.gov.

Applying for a Social Security number is free. Failure to provide the SSN means that Claims for otherwise eligible individuals may not be considered a payable Claim until your Dependent's SSN is received by the TBT Plan Administration Office. Contact Plan representatives if you need help applying for a Dependent's SSN.

## Special Enrollment Rights

If you have a new Dependent because of marriage, birth, adoption or placement for adoption, you may be able to enroll your Dependent in your TBT Plan. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you do not enroll your new Dependent within 30 days after the marriage, birth, adoption or placement for adoption, their coverage will not begin until the month following the month the TBT Plan Administration Office receives the Dependent enrollment information. To request special enrollment or obtain more information, contact the TBT Plan Administration Office.

## Medicaid or a State Children's Health Insurance Program (CHIP)

Provided that you meet the Plan eligibility requirements, you and your Dependents **may also enroll in the Plan** if you (or your eligible Dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment in the Plan **within 60 days** after the Medicaid or CHIP coverage ends, or
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan **within 60 days** after you (or your Dependents) are determined to be eligible for such premium assistance.

## 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, add or remove 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 have stepchildren that you want to cover as Dependent Children.
6. Due to divorce, your stepchildren are no longer eligible for coverage.
7. Your covered child loses coverage due to age.
8. A covered family member dies.

**With your notice, send a copy of your:**

- Marriage certificate.
- Certification of Domestic Partnership.
- Divorce decree.
- Birth certificate.
- Adoption or legal guardianship documents.

**Note:** Evidence of a child's status as an eligible Dependent (including a court order of adoption or an order appointing you as the child's legal guardian) is required as explained on this page.

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

### *DIVORCE NOTICE REQUIRED WITHIN 30 DAYS*

*A newly divorced participant must notify the TBT Plan Administration Office* ***within 30 days*** *of a formal court order granting termination of the marriage or registered Domestic Partnership. If you do not notify TBT* ***within 30 days****, you are responsible for paying Claims accrued by your former Spouse or Domestic Partner and stepchildren following the 30-day deadline when you did not provide timely notice to TBT, as required.*

*See* ***When Coverage Ends*** *on page 9 for details regarding coverage ending for your former Spouse or Domestic Partner and covered Dependents who may no longer qualify as eligible Dependents as defined by the Plan.*

***Again, if you and your Spouse divorce (or you and your Domestic Partner end your registered Domestic Partnership) but never inform the Trust, the Trust will make you pay for any Claims it paid for your former Spouse or Domestic Partner and stepchildren following the divorce or termination of the Domestic Partnership.***

## HOW TO ENROLL

Once you are eligible for coverage, 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 pages 10-11).

You enroll yourself and your eligible Dependents by completing the following forms (mailed to you by the TBT Plan Administration Office):

1. **TBT Enrollment Form.** The process of starting your benefits won't begin until this form is received (see *Why Enroll?* on page 8).
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 (as explained on the form).

**With your completed enrollment forms, send a copy of your:**

- Marriage certificate.
- Certification of Domestic Partnership.
- Birth certificate.
- Adoption or legal guardianship documents.

*HMO Application.* An HMO application is required for either new or continued HMO coverage (see *How to Apply for HMO Coverage* on page 9). If you need an HMO packet and application, contact the TBT Plan Administration Office. If you select HMO coverage, all your covered Dependents will also be enrolled in HMO coverage.

## Why Enroll?

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

1. Coverage is not automatic. If you do not enroll within 30 days after you first become eligible, you may lose the opportunity to enroll in the TBT medical and dental options of your choice.
2. If you do not return the *Medical Option Form*, you are automatically enrolled in the Indemnity Medical Option. Your coverage will be retroactive to your initial eligibility date (although your Dependent's coverage will not be retroactive); however, no Claims are paid until your *TBT Enrollment Form* and *Medical Option Form* are on file with the TBT Plan Administration Office. If TBT would be materially harmed by the delay in submitting your *TBT Enrollment Form* (for example, a Claim otherwise eligible for stop-loss reinsurance is ineligible for reimbursement because of the late enrollment), your coverage may be delayed until the first day of the second month following receipt of your *TBT Enrollment Form* (see *Effective Date of Open Enrollment Changes* on page 10).
3. If you want medical coverage under an HMO, you are not enrolled in the HMO until the TBT Plan Administration Office receives your *TBT Enrollment Form* and *Medical Option Form* plus your HMO application. **Note:** The medical HMOs do not accept applications with an effective date that occurs more than 60 days before the HMO has received the HMO application.
4. 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*. You may order an additional prescription drug ID card for a covered child who lives away from home by calling Anthem CarelonRx at the number listed on page 91. If you are eligible for prescription drug benefits, but have not yet received your prescription drug ID card, your pharmacy can contact Anthem CarelonRx for instructions on how to process your Claim.
5. You have no dental coverage until you send in the *Dental Option Form*.
6. You will not receive important notices about your benefits because the Plan does not have your mailing address.
7. If the Plan provides for death benefits or life insurance, you will not have named a beneficiary to receive Plan benefits if you die or are seriously injured. (You designate your beneficiary on your *TBT Enrollment Form*.)
8. You and your covered Dependents will likely face delays when you need to use your benefits—or may even need to pay expenses that would otherwise have been covered by the Plan.
9. Providers cannot verify your coverage.

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

## How Coverage Continues

Once coverage begins, you and your covered Dependents continue to be eligible for benefits as long as you remain employed by a contributing Employer, work (or are paid for—for example, paid sick leave) the required number of hours (if applicable) and your Employer makes monthly contributions on your behalf.

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 9).

## Are You Moving?

Whenever you move or change your address or phone number, you must provide the Trust with the changes. Send a completed *Change of Address Form* to the TBT Plan Administration Office. You must use this official form to update your Plan information. Don't delay or you might miss important notices about your benefits.

Download this and other forms from the TBT website at www.tbtfund.org. You may fax, email or bring the completed form to the TBT Plan Administration Office.

Remember, TBT keeps one address and phone number on file for each participant. If your Spouse or other Dependents do not live with you, make sure they know that *all TBT mail is sent to your address*.

## WHEN COVERAGE ENDS

Coverage for you and your 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. The date when your TBT Plan is terminated, or the Trust Fund is terminated.

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 Domestic Partner, when your Domestic Partnership ends (on the first day of the month after your registered Domestic Partnership is terminated).
3. For your Dependent child, on the first day of the month after he or she turns age 26. (See *Who Is Eligible as a Dependent Child?* on page 6).

For information on COBRA Continuation Coverage, see pages 14-20.

### When the Plan Can End Your Coverage for Cause

In accordance with the requirements of the Affordable Care Act, the Plan will not retroactively cancel coverage (known as a "rescission") except in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan; or as otherwise allowed by federal law.

If your coverage is terminated for cause or intentional misrepresentation (as explained in column 1), it will end after 30 days' written notice, retroactive to the date when you or your covered Dependent performed or permitted the acts described. **For this purpose, keeping an ineligible dependent enrolled under the Plan (for example, when a Dependent child is no longer eligible or for a former Spouse after divorce) is considered fraud.**

### 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 (explained on page 4).

### Reenrollment in HMOs

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

### If You Have Eligibility Questions

Call the TBT Plan Administration Office at the phone numbers on page 1.

***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.*

## ENROLLING IN THE INDEMNITY MEDICAL OPTION OR HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

TBT offers a choice of medical coverage. You may choose the Indemnity Medical Option explained beginning on page 22 or other coverage under a Health Maintenance Organization (HMO) offered through TBT (explained on this page and page 10).

The Indemnity Medical Option is available no matter where you live. To choose an HMO option available through TBT, you must live within the HMO service area where coverage is available. The *Comparison of Medical Benefits* lists the service areas for each HMO by county. Check with each HMO for the most current details about their service areas and facilities. Their phone numbers and websites are listed on page 91.

### How to Apply for HMO Coverage

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

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

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

The HMO *Evidence of Coverage* is contained in the HMO enrollment packet already provided to you or can be obtained by calling the TBT Plan Administration Office.

### Other TBT Benefits for HMO Participants

HMO participation only applies to medical coverage. Other TBT benefits (such as prescription drug, vision, dental and other benefits described in your *Summary of Coverage*) are as described in this *Guide* regardless of which TBT medical option you choose.

**Exception:** If you are enrolled in the Kaiser HMO, TBT Plans I-A, III-A, V-A and VI only provide prescription drug benefits through Kaiser facility pharmacies (rather than through TBT's prescription drug program).

Under these TBT Plans, the Kaiser HMO also requires that you use their drug formulary's medications that are approved by a Kaiser pharmacy in your service area. For details, contact Kaiser Member Services at the number listed on page 91.

### Dental Options

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

- *Dental Options* on page 42.
- Prepaid Dental Plans (Options 2 and 3) on page 42 in column 3, and
- Your *Summary of Coverage* and *Comparison of Dental Benefits*.

### Differences Between the TBT Indemnity Medical Option and the HMO Option

There are important differences between coverage under the TBT Indemnity Medical Option and HMOs:

1. HMOs limit you to HMO Providers. If you choose HMO coverage and go to a Hospital, Doctor or health care Provider that is not in the HMO, your Claims are not covered by the HMO (unless the Claim is for HMO-recognized Services).

   Packets explaining HMO coverage, service areas, non-covered Claims and appeal and denial procedures, enrollment applications and forms are available through the TBT Plan Administration Office. You may also request the HMO's *Evidence of Coverage* by calling their phone number listed on page 91.
2. HMO participants must contact the HMO directly about benefit questions and Claims appeals. Phone numbers for the HMOs currently offered by TBT are listed on page 91. Note that the HMOs offered by TBT may change.

## OPEN ENROLLMENT—CHANGING YOUR MEDICAL OR DENTAL OPTION

TBT has a "rolling" Open Enrollment. 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.

**Note:** You will receive a *Summary of Benefits and Coverage* for your current medical option when required. You will not be sent medical and/or dental option change forms unless you request them.

### 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 HMO materials you would like to review. This form may be downloaded at www.tbtfund.org. You may also request the form from the TBT Plan Administration Office.
3. You will receive the materials you requested and the required enrollment change forms. Once you review the materials, fill out and send the *Medical Option Change Form* and/or *Dental Option Change Form* to the TBT Plan Administration Office.

### 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. **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.

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 call the TBT Plan Administration Office to:

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

When you call, 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.

***EXCEPTION***

*You may change to the Indemnity Medical Option when you move out of an HMO's 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.*

**You and your eligible Dependents must be covered under the same medical and/or dental options. Contact the TBT Plan Administration Office with questions.**

## FAMILY AND MEDICAL LEAVE

The Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) provide that if you work for an Employer covered by that Act, you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own illness for up to 12 weeks per year (in some cases, up to 26 weeks per year).

In general, the employers covered by FMLA and CFRA are those who employ five or more employees for each working day during each of 20 or more calendar weeks in the current or preceding calendar year. If you are taking FMLA or CFRA leave that has been approved by your Employer, your Employer is responsible for making contributions to the Trust Fund on your behalf, as if you are working, to maintain your eligibility.

To learn more about Family or Medical Leave and the terms which may entitle you to it, contact your Employer.

**FMLA eligibility is not automatic. *You* must contact your Employer before taking FMLA or CFRA leave. Unless the leave is approved, your Employer will not submit the contributions for your coverage and you will lose eligibility.**

At the end of the FMLA leave, you may be eligible for COBRA Continuation Coverage if you experience a Qualifying Event (see pages 15-16).

## LEAVE FOR MILITARY SERVICE

If you go on leave from your covered employment, either voluntarily or involuntarily for active duty or training in the uniformed services, 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 (a rate which is the same as the COBRA contribution described on page 17).

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 Veterans Affairs to occur or be aggravated during performance of service in the uniformed services.

Regardless of whether 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 1st 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 *Paying for Coverage* on page 17) your coverage will end immediately. You may elect either Core Coverage or Core Plus Coverage (explained under *Levels of Coverage* on page 17).

Unlike COBRA Continuation Coverage, if you do not elect USERRA, your Dependents cannot elect USERRA separately. However, you and your Dependents may be eligible for COBRA Continuation Coverage (see pages 14-20). USERRA is an alternative to COBRA.

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 in this *Guide*. 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.

### *TRICARE*

You or your eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). More information about TRICARE is available at www.tricare.mil or by calling (800) 538-9552 or (866) 363-2883.

## EXTENSION OF COVERAGE WHILE TOTALLY DISABLED

If you are eligible and rendered unable to work because you become Totally Disabled due to an illness or injury (see the definition on page 82), you may qualify to apply for continued coverage for yourself and your covered Dependents for up to three months.

If you remain Totally Disabled 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 page 17.

Months when you make self-payments for extended coverage will count toward your maximum allowable months of COBRA eligibility. 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 an 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 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 behalf 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.

### If the Applicant is a Participant

Under the Plan's definition of "Total Disability," an application made on behalf of a participant for disabled status must answer:

1. *Does he or she have a physical or mental condition requiring a Doctor's care?*

   This would generally be shown by a written certification from the participant's Doctor that includes, at minimum, the diagnosis for the disabling condition, its severity, its expected duration and the prognosis.

2. *Can he or she perform either his or her regular duties as an Employee or any employment for wages or profit?*

   This requires a description of the participant's ability to do work-related activities. The application must (a) describe the specific physical and/or mental limitations that affect the participant's ability to work, and (b) explain why those limitations prevent the participant from performing either his or her regular job duties or any other paid employment. This may require a description of the participant's current job duties and prospects for alternative employment, including work experience, skills and education.

3. *Is the condition related to the commission of a felony or due to injury or illness related to military service?*

   If not clear from the application itself, the Doctor's statement should address whether the disabling condition is caused by one of these events.

### If the Applicant is a Dependent

Under the Plan's definition of Total Disability, an application made on behalf of a Dependent for disabled status must answer:

1. *Is he or she unable to earn a living because of a physical or mental disability?*

   This requires a description of the Dependent's ability to do work-related activities. The application must (a) describe the specific physical and/or mental limitations that affect the Dependent's ability to work, and (b) explain why those limitations prevent the Dependent from earning a living. An applicant may wish to include a report from a vocational expert in addition to a Doctor's certification.

2. *Has a Doctor certified in writing, upon request, and no more than once a year, that the individual's physical or mental disability prevents him or her from doing the regular and customary activities for a person of the same age?*

   The Doctor's statement should specify which activities the Dependent is unable to perform. Under this standard, simply being subject to a "limitation" (for example, cannot lift more than 20 pounds, cannot sit for more than four hours at a time) is not sufficient—the disability must prevent the Dependent from performing customary activities for a person of the same age.

   The application should specify which activities the disability renders the Dependent unable to perform (for example, attend school, work or other activities). Mitigating factors—such as medication, prosthetic devices, reasonable accommodation, or other factors—should be considered in the determination of whether the disability is severe enough to qualify for the extension. In other words, if an otherwise disabling condition can be controlled or accommodated to permit the Dependent to engage in the specified activity, he or she will generally not be considered disabled.

3. *Is the condition related to injury or illness in connection with military service?*

   If not clear from the application itself, the Doctor's statement should address whether the disabling condition is caused by an injury or illness related to military service.

**The Board of Trustees reserves the discretion to interpret and apply these guidelines and the right to modify the guidelines at any time. The Board of Trustees may also, in its discretion, consult a reviewing Physician or other qualified expert(s) or request that the applicant obtain a second opinion from a qualified Doctor selected by the Board of Trustees.**

# CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (a federal law commonly called COBRA) the Plan must offer Employees and their covered Dependents (called Qualified Beneficiaries) the opportunity to temporarily extend coverage at group rates when coverage would otherwise end because of certain events (called Qualifying Events). Evidence of your good health is not required. However, you must pay for the coverage you elect. The Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person's COBRA rights.

### PROCEDURE FOR NOTIFYING THE PLAN

*To have the opportunity to elect COBRA Continuation Coverage after loss of coverage due to a divorce or legal separation, or a child ceasing to be a "Dependent child" under the Plan,* ***you and/or a family member must inform the Plan IN WRITING of that event no later than 60 days AFTER THAT QUALIFYING EVENT OCCURS****. (More information on this, as well as a definition of Qualifying Event, are provided in this section.)*

*That written notice should be sent to the TBT Plan Administration Office at the address listed on page 91. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event and appropriate documentation in support of the Qualifying Event, such as divorce documents.*

***Note: If such a notice is NOT received by the COBRA Administrator WITHIN THE 60-DAY PERIOD, you will NOT be entitled to choose COBRA Continuation Coverage.***

## Other Health Coverage Alternatives to COBRA

Because you must pay a premium each month to have COBRA coverage, you might want to consider other potentially less expensive alternatives.

### *Health Insurance Marketplace (Covered California) and/or Medi-Cal*

When you lose Employer-paid coverage, you will generally be eligible to purchase coverage through the Health Insurance Marketplace commonly referred to as "Covered California." Based on your family income, you may be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. For more information visit www.coveredca.com.

You may be directed to Medi-Cal if the information you provide demonstrates you and your family may qualify, and you may apply through the same website. If you do not live in California during the off-season, see your state Health Insurance Marketplace or www.healthcare.gov.

### *Other Group Coverage*

You may qualify for special enrollment under your Spouse's or some other group health plan for which you are eligible, even if that other plan does not accept late enrollees. See your Spouse's (or the other group health plan's) special enrollment provisions for more information and deadlines. But generally, enrollment must be requested **within 30 days** of losing coverage under this Plan.

## Who Is Eligible for COBRA Coverage

Employees may be eligible for COBRA Continuation Coverage when they lose coverage for the following reasons:

- Hours of employment are reduced below what is required under your Collective Bargaining Agreement for your Employer to make a contribution on your behalf. The reduction may be because of layoff, disability, industrial injury, approved leave or any other reason. For example, your Collective Bargaining Agreement provides that your Employer is required to contribute when you work or are paid for 80 or more hours in a month, and you work or are paid for only 70 hours in a month.
- Termination.
- Retirement.

Dependents may be eligible for COBRA Continuation Coverage when they lose coverage because:

- The Employee lost coverage.
- The Employee died.
- The child no longer qualifies as a Dependent because the child is over age 26 or the Employee becomes divorced or legally separated and this causes the child to lose coverage (for example, the dependent child was a stepchild of the Employee).

## COBRA Administrator

The COBRA Administrator is the TBT Plan Administration Office. The name, address and phone number are shown on page 1.

## When COBRA Coverage Begins

If you choose COBRA coverage at any time during the 60-day election period, coverage will be retroactive to the date coverage was lost due to the Qualifying Event. If you or your Dependents decide to waive COBRA coverage, you do not need to notify the COBRA Administrator or complete any forms to waive COBRA. You will simply not submit a COBRA election form within the 60-day election period. Remember, you may not elect COBRA coverage after the 60-day election period ends.

## Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, which, under this Plan, is measured from the date coverage was lost on account of the Qualifying Event. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described on page 12 regarding extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on *Notice of Early Termination of COBRA* on page 20.

## Procedure for Notifying the Plan of a Qualifying Event

To elect COBRA Continuation Coverage after loss of coverage due to a child ceasing to be a "Dependent child" under the Plan, ***you and/or a family member must inform the Plan in writing*** **of that event no later than** ***60 days after that Qualifying Event occurs***.

That written notice should be sent to the COBRA Administrator, the TBT Plan Administration Office, at the contact information on page 1. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event and appropriate documentation in support of the Qualifying Event, such as divorce documents.

> ***Note:*** *If such a notice is* ***not*** *received by the COBRA Administrator* ***within the 60-day period****, the Qualified Beneficiary will* ***not*** *be entitled to choose COBRA Continuation Coverage.*

Your Employer should notify the COBRA Administrator (the TBT Plan Administration Office) within 31 days of these events: an Employee's death, termination of employment including retirement, reduction in hours making the Employee ineligible for coverage or entitlement to Medicare (if the event causes the Employee to be ineligible for coverage). However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs to avoid confusion over the status of your health care due to a delay or oversight in providing that notification.

## Notices Related to COBRA Continuation Coverage

When the COBRA Administrator is notified of a Qualifying Event, the COBRA Administrator will give you and/or your covered Dependents notice of the date when your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. ***Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.*** Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

> ***Note:*** *If you and/or any of your covered Dependents do not elect COBRA coverage* ***within 60 days*** *after receiving notice, you and/or they will have no coverage from this Plan after the date coverage ends.*

To help ensure that your COBRA coverage is properly administered, you must also notify the COBRA Administrator of your or your Dependent's enrollment in Medicare.

If the COBRA Administrator is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation describing why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

## Electing COBRA Coverage

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, **and** due to that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including special enrollment and Open Enrollment (as applicable).

1. *"Qualified Beneficiary"*—A Qualified Beneficiary is any Plan participant or Spouse or child or the Dependent child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent child by birth, adoption or placement for adoption, or marriage or Domestic Partnership with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent child.
2. *"Qualifying Event"*—Qualifying Events are those shown in the chart on this page. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, due to the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a Qualifying Event but, as a result, **does not lose** health care coverage under this Plan (for example, because the Employee continues working even though entitled to Medicare), then COBRA is not available.

The following chart lists the COBRA Qualifying Events, those who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

| COBRA Qualifying Event | Duration of COBRA for Qualified Beneficiaries[1] | |
|---|---|---|
| | Employee | Dependents |
| Employee terminates, including retirement. | 18 months | 18 months |
| Employee reduction in hours worked (making Employee ineligible for health care coverage—for example, working fewer than 80 hours required for eligibility if that is what your Collective Bargaining Agreement requires). | 18 months | 18 months |
| Employee dies. | N/A | 36 months |
| Employee becomes divorced, legally separated, or terminates Domestic Partnership (if the divorce, separation, or termination of Domestic Partnership causes Dependent to lose eligibility for coverage). | N/A | 36 months |
| Dependent child ceases to have Dependent status or qualify as a Dependent. | N/A | 36 months |

[1] *When a covered Employee's Qualifying Event (such as termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Dependents who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or, as applicable, 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you, and then enroll under the other group health plan after COBRA coverage ends.

## COBRA Continuation Coverage Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you or your Dependents are required to pay monthly for it.

See the section on *Paying for Coverage* that appears below for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Employees and their families, that same change will apply to your COBRA Continuation Coverage.

## Levels of Coverage

You may elect and pay for *one of the following* levels of COBRA coverage:

- **Core Coverage** for medical and prescription drug benefits alone, or
- **Core Plus Coverage** for medical and prescription drug benefits PLUS vision and dental benefits.

Your COBRA payments will be higher if you elect the Core Plus Coverage option that includes vision and dental benefits.

If Plan coverage is changed for active Employees while you or your Dependents are on COBRA coverage, the same changes will apply to you and your Dependents.

## Paying for Coverage

If you elect COBRA Continuation Coverage, you pay the full cost of coverage for you and your Dependents plus a **2%** administration fee—in other words, **102%** of the cost. If you are Disabled and qualify for the COBRA extension, the cost of COBRA Continuation Coverage for the additional 11 months (from the 19th to the 29th month of COBRA coverage) will be **150%** of the cost.

The cost of COBRA is determined annually by the TBT Board of Trustees.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time they become entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

The **first payment for COBRA Continuation Coverage** is due to the COBRA Administrator (the TBT Plan Administration Office at the address shown on page 1) **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. The first payment covers the cost of COBRA coverage retroactive to the date your Employer-paid coverage ended.

**You are responsible for ensuring that the amount of your first payment is enough to cover this entire period.** You may contact the COBRA Administrator to confirm the correct amount of your first payment. If the first payment is not received by the end of the 45-day grace period after COBRA is elected, your COBRA coverage will not take effect and you must pay any health care expenses incurred during that period.

After you make the first payment, **subsequent COBRA payments** are due on the 1st day of each month. Payments are considered late if they are not received within 30 days of the due date (a 30-day grace period). If any of your COBRA payments are late, COBRA Continuation Coverage **will be canceled as of the due date, and you will lose all your COBRA coverage rights**. Payment is considered made when it is postmarked.

**IMPORTANT**

*TBT will not send you a bill or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.*

## COBRA Payment Shortfalls

*Significant Shortfall in Payment:* If you or your Dependent send a timely monthly contribution to the COBRA Administrator that is **significantly less** than the actual COBRA payment due for the month, your or your Dependent's COBRA coverage will be terminated immediately. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of **$50** or **10%** of the required COBRA premium payment.

*Not Significant Shortfall in Payment:* If the shortfall is not significant, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. **You or your Dependent are responsible for paying all deficiencies.**

- If the **shortfall is paid** within the 30-day period, then COBRA Continuation Coverage will continue for the month in which the shortfall occurred.
- If the **shortfall is not paid** within the 30-day period, then COBRA Continuation Coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

If you have any questions about COBRA or need additional forms, call the COBRA Administrator (the TBT Plan Administration Office) at their phone number listed on page 1.

### Payment of Claims

Once you enroll in COBRA Continuation Coverage and pay the first premium payment, Claims are payable from the effective date of COBRA coverage. The Plan will continue to pay Claims for the length of your COBRA Continuation Coverage, provided you pay the monthly premiums on time without a significant shortfall.

If you or your Dependents do not elect COBRA coverage or pay the premium, the Plan will not pay benefits for any expenses incurred by you or your Dependents after the date coverage ended. Except as described under the Medical Extension of Coverage, this applies to conditions being treated before coverage ended.

### Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you or your Dependents have elected COBRA Continuation Coverage, and the amount required for COBRA Continuation Coverage has not been paid while the initial grace period is still in effect or you or your Dependent(s) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no Claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

### Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) or the surviving family members of such individuals. Eligible individuals can either take a tax credit or get advance payment of **72.5%** of premiums paid for qualified health insurance including COBRA. For more information, visit www.irs.gov/HCTC.

### Addition of New Dependents

If, while you are enrolled in COBRA Continuation Coverage (meaning that you timely elected COBRA and paid your premium), you have a newborn child, adopt a child or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage—provided you do so within 31 days after the birth, adoption or placement for adoption. Then the child will be entitled to the full duration of COBRA.

Adding a Dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator (the TBT Plan Administration Office) to add a Dependent.

### Loss of Other Group Health Plan Coverage

If your Dependent loses coverage under another group health plan while you are enrolled in COBRA Continuation Coverage, you may enroll the Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Dependent must have been eligible but not enrolled in coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Dependent within 31 days after the termination of the other coverage. Adding a Dependent may cause an increase in the amount you must pay monthly for COBRA Continuation Coverage.

Loss of coverage also includes a Dependent who loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). Enrollment in COBRA must be requested within 60 days after the Medicaid or CHIP coverage ends.

To request enrollment in COBRA for an eligible Dependent under Special Enrollment, the Qualified Beneficiary must request enrollment within 30 days (60 days for CHIP) after the date on which the Dependent first becomes eligible for Special Enrollment by contacting the COBRA Administrator and completing and submitting an enrollment form. Adding a Dependent may cause an increase in the amount you pay for COBRA Continuation Coverage.

## Extensions for 18-month COBRA Coverage Periods

The 18-month coverage period may be extended under the following circumstances:

### *Second Qualifying Event Extension*

If your Dependents are entitled to COBRA coverage as a result of your termination of employment or reduction of hours, and they later experience a second Qualifying Event within this 18-month period that would have resulted in a loss of coverage if not for the COBRA coverage, coverage may be extended an additional 18 months—for a total COBRA coverage period of up to 36 months from the initial Qualifying Event.

Second Qualifying Events may include the death of the covered Employee, divorce or legal separation from the covered Employee or a Dependent child ceasing to be eligible for coverage as a Dependent under the group health plan.

To extend COBRA when a second Qualifying Event occurs, you or your Qualified Beneficiary must notify the COBRA Administrator (the TBT Plan Administration Office) in writing within 60 days of a second Qualifying Event. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.** The written notice must include your name, the second Qualifying Event, the date of the second Qualifying Event and appropriate documentation in support of the second Qualifying Event.

This extended period of COBRA Continuation Coverage is available to any child born to, adopted by or placed for adoption with you (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated, or who had a reduction in hours, entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage due to disability as described in this section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

**In no case will COBRA Continuation Coverage be extended for more than a total of 36 months.**

### *Disability Extension*

If you or your covered Dependents were Disabled (as determined by the Social Security Administration) on the date of the Qualifying Event or at any time during the first 60 days after the date of your COBRA Qualifying Event, you and your Dependents may continue coverage under COBRA for up to 29 months (11 months plus the regular 18 months of COBRA). For months 19 through 29, you pay a higher premium (**150%** of the total cost).

This extension is available only if the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage and the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

You must submit written notification of the Social Security determination of Disability to the COBRA Administrator no later than 60 days after the loss of coverage or the date you or your Dependent received the Social Security determination (whichever is later). **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.** The written notice must include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation. The notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

Newborns and adopted Children who are determined to be Disabled by the Social Security Administration within the first 60 days of birth or placement for adoption are treated as having been Disabled within the first 60 days of COBRA coverage.

You or your Dependents are responsible for notifying the COBRA Administrator (the TBT Plan Administration Office) within 60 days of receiving the Social Security Administration's determination of Disability and before the end of the initial 18-month period of COBRA coverage. Contact information for the COBRA Administrator is the TBT Plan Administration Office listed on page 1.

If you or your Dependents were determined to be Disabled before COBRA coverage began, the extension is valid as long as the determination was still in effect on the first day of COBRA coverage.

If you or your Dependents are on extended COBRA coverage because of a Disability, you must notify the COBRA Administrator within 30 days of the date you or your Dependent receive the Social Security Administration's determination that you or your Dependent are no longer Disabled. The disability extension will end on the first day of the month that is more than 30 days after the Disability ends. You must send your notice to the COBRA Administrator.

## When COBRA Coverage Ends

COBRA coverage **will end on the earliest** of:

1. The end of the 18-, 29- or 36-month period.
2. The date a COBRA coverage payment is not **paid in full and on time**.
3. The date the Qualified Beneficiary becomes covered, after the COBRA election, under another Group Plan.
4. The date the Qualified Beneficiary becomes covered, after the COBRA election, under Medicare Part A or Part B. (COBRA coverage ends only for the person who becomes covered by Medicare.)
5. The first day of the month beginning more than 30 days after the date an individual on the 29-month disability extension described on this page is determined to be no longer Disabled according to the Social Security Administration.
6. The date determined by TBT that your Plan coverage will terminate due to fraud or intentional misrepresentation, or because you knowingly provided TBT or the COBRA Administrator (TBT Plan Administration Office) with false material information including, but not limited to, information relating to another person's eligibility for coverage or status as a Dependent. TBT has the right, after providing 30 days' advance written notice, to cancel coverage back to the effective date of coverage.
7. The date the Fund no longer provides group health coverage to any Plan participants.

*Notice of Early Termination of COBRA:* If COBRA coverage ends prior to the 18-, 29- or 36-month coverage period, the COBRA Administrator will provide a notice to the affected individuals as soon as practicable following the COBRA Administrator's determination of the termination of COBRA coverage. The notice will explain the reason for the early termination, the date of the termination and the availability of alternative group or individual coverage, if any.

> *If you are Disabled when all coverage ends under the Medical Plan, you may be entitled to extended benefits. For information, see* Extension of Coverage While Totally Disabled *on page 12.*

Once COBRA coverage terminates early, it cannot be reinstated. There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

## COBRA Questions

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of the Regional and District EBSA offices are available through this website.

COBRA Continuation Coverage is available to Domestic Partners and their Children to the same degree and in the same manner as Continuation Coverage is available to Spouses and stepchildren.

# 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 a TBT-sponsored Health Maintenance Organization (HMO) available where you live. Each option is explained in greater detail on this page and in the *Comparison of Medical Benefits* for your TBT Plan.

### *Comparison of Medical Benefits*

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

The *Comparison of Medical Benefits* is a summary only. It does not fully describe your TBT Plan's medical benefits. If you have coverage through an HMO offered by TBT, these benefits are explained in separate materials from the HMO.

## HMO OPTION

If you enroll in an HMO, you must receive non-emergency services from a Provider either employed by the HMO or who has contracted with the HMO. The HMO must determine that the services and supplies are Medically Necessary, as defined by the HMO, to prevent, diagnose or treat your medical condition. The services and supplies must be provided, prescribed, authorized or directed by an HMO Physician.

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

The *Evidence of Coverage* is the binding document between the HMO and its members. It is sent to you by the TBT Plan Administration Office when you enroll. You may request the HMO's most current copy by calling their phone number listed on page 91.

For details about a TBT-sponsored HMO's benefit and claims review and decision procedures, refer to the HMO's *Evidence of Coverage*. See the HMO's website found in the TBT Provider List on page 91 to find the most recent list of HMO facilities and locations.

***REMINDER***

*To enroll in an HMO offered through TBT, you must live in the HMO's service area. However, your Dependent child who lives separately from you will remain eligible for coverage with the HMO even if residing outside of the HMO's service area. Detailed information about an HMO option available through TBT may be found in the separate materials from these organizations. For information about a TBT-sponsored HMO option in your area, call the TBT Plan Administration Office.*

# Indemnity Medical Plan Option

This section explains your medical benefits through the Indemnity Medical Option. You also need to check your *Comparison of Medical Benefits* and *Summary of Coverage* for specific information about your TBT Plan, such as the Plan number, calendar year Deductibles, Copayments, Coinsurance percentages, special benefits and maximum amounts.

If you have coverage through an HMO offered by TBT, these benefits are explained in separate materials provided by the HMO. See page 21 for more information about the HMO Option.

You may also periodically receive *Plan Change Notices* or a *Summary of Material Modifications* (SMM) explaining important changes to your coverage. Keep these notices in this package so you can refer to the most current information about your benefits. SMMs are also posted under "Plan Notices" at www.tbtfund.org.

## WHAT IS COVERED

The Indemnity Medical Option pays for Medically Necessary services and supplies authorized by a Doctor for treatment of illness or injury to you or your covered Dependents and for preventive health care services required by the Patient Protection and Affordable Care Act.

For more information on what the Indemnity Medical Option covers, see *How Benefits Are Paid* starting on page 23. The amount your TBT Plan pays depends on whether the Claims were incurred in-network or out-of-network, explained next.

### PPO Providers

The Anthem Blue Cross 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 and alcohol or chemical dependency treatment Providers and other Preferred Providers.

Costs for covered services from PPO Providers are usually lower than charges for the same services by non-PPO Providers because Providers in the PPO Network are under a contract with the PPO and have agreed to accept a discounted amount for covered services.

See the Anthem Blue Cross website at www.anthem.com/ca to find current PPO Providers. Since participating Providers change often, always confirm with a Doctor's office or Hospital that it is a PPO Provider before receiving services. California residents can verify that their Provider is in the PPO by calling (888) 887-3725. Non-California residents can verify that their Provider is in the PPO by calling (800) 810-2583 or by visiting www.anthem.com/ca.

You are responsible for payment of Deductibles, Coinsurance or Copayments. See your *Summary of Coverage* for the Plan's specific cost-sharing provisions.

### Non-Network Providers

If you receive service from a Non-PPO Provider, the Plan will pay Usual, Customary and Reasonable charges (UCR) as defined on page 86. If your Non-PPO Provider's charges are higher than what your TBT Plan determines to be UCR, you pay for the difference between the Non-PPO Provider's charges and the Allowed UCR Amounts. This is called "Balance Billing." A PPO Provider may not "Balance Bill" you for covered services.

If the services from a Non-PPO Provider are covered by the *No Surprises Act* explained on page 25, your out-of-pocket charges will be comparable to what they would have been if the services were provided by a PPO Provider.

Because any amount that exceeds what the Plan has determined to be UCR is not a Covered Expense, **this portion of your payment to the Non-PPO Provider does not apply to your Plan's Coinsurance percentages and Out-of-Pocket Limits for the calendar year**. See your Plan's *Summary of Coverage* for details.

## DETERMINING THE AMOUNT YOU PAY UNDER THE PLAN

### Deductible

Under the Indemnity Medical Option, the Deductible is the amount you owe each calendar year for health care services that are covered before your Plan begins to pay. The Deductible does not apply to all services (such as most preventive services). Your TBT Plan's Deductible amounts are listed in your *Summary of Coverage*. **A "Deductible" is not the same thing as "Coinsurance"—see that definition on this page.**

Each covered person has a separate Deductible for covered medical expenses each calendar year up to a family maximum. After you and your covered Dependents meet the family maximum Deductible listed in your *Summary of Coverage*, no additional Deductibles are required to be paid for individual members of your family for the rest of the calendar year.

A Carryover Rule applies to all Plans *except Plan IV*. Under the Carryover Rule, any Covered Expenses that you or an eligible Dependent incur during the last three months of the calendar year that apply to the Deductibles, will also apply to the Deductibles for the next calendar year. You do not need to meet the Deductible for some services such as Preventive Care. See your *Summary of Coverage* and *Comparison of Medical Benefits* for information specific to your Plan.

### Coinsurance

In addition to the Deductible, you are responsible for a share of the costs of a covered health care service calculated as a percentage. For example, if your Plan is an "**80%/20%** plan," the Plan pays **80%** and you pay **20%** until you reach your annual Out-of-Pocket Maximum of the Allowed Amount for the service. These amounts you pay are called "Coinsurance."

Your *Summary of Coverage* lists the Coinsurance percentage your TBT Plan pays for each Covered Service.

If you use a **Non-PPO Provider**, you are responsible for paying any charges higher than the Plan determines to be Usual, Customary and Reasonable (UCR). Charges in excess of UCR are not covered charges and are *your* responsibility to pay unless the service is protected by the *No Surprises Act* (explained on page 25).

### Out-of-Pocket Maximum

If the Covered Expenses you pay reach your Plan's Out-of-Pocket Maximum (see your *Summary of Coverage*) during any calendar year in which you and/or your family have satisfied your Deductible, Covered Expenses for the balance of the calendar year are paid at **100%**. However, if you use a Non-PPO Provider, you remain responsible for paying any **non-covered charges for non-emergency services**, such as any billed amounts that exceed UCR charges.

**Note: Your Plan has a separate Out-of-Pocket Limit for medical expenses and prescription drug expenses.** See your Plan's *Summary of Coverage*.

The following are examples of expenses that do not apply toward meeting your annual Out-of-Pocket Limit:

- The amount of Coinsurance owed for an inpatient stay in a Non-PPO Hospital for non-emergency services.
- Non-Covered Expenses—such as charges by a Non-PPO Provider that are higher than Usual, Customary and Reasonable (UCR) and are not protected by the *No Surprises Act*. See page 25.

## HOW BENEFITS ARE PAID

### Preventive Care Services

**If you use a PPO Provider for Preventive Care,** your Plan pays for all approved Preventive Care services for you and your Dependents without cost-sharing (meaning no Copayment, no Coinsurance and the Plan Deductible does not apply). See the supplement to this *Guide* titled *Preventive Care and Wellness Benefits*.

If you use a Non-PPO Provider for Preventive Care, you pay your Coinsurance percentage toward the cost of allowable UCR charges for covered services plus any additional Balance Billing. See your *Summary of Coverage* for the Plan's Coinsurance percentages when you receive Preventive Care services from Non-PPO Providers.

## Wellness Support

TBT has engaged HMC HealthWorks (also called Uprise Health) to administer **"TBT Healthy Lifestyles"** free of charge for all participants and their covered Dependents who have one or more of these chronic conditions:

- Coronary Artery Disease (CAD).
- At-Risk Cardiac.
- High Blood Pressure.
- High Cholesterol.
- Diabetes.
- Chronic Obstruction Pulmonary Disease (COPD).
- Asthma.
- Back Pain.

The Healthy Lifestyles program includes live outreach calls to chronic condition patients by registered nurses or certified wellness coaches who explain how to manage or improve the patient's chronic conditions. Outreach may include educational packets, newsletters, podcasts, email messages and postcards.

Health coaches are available by phone or online for wellness support for the following:

- Weight Management Support.
- Nutrition and Exercise Tips.
- Healthy Eating Guidance.
- Stress Management.
- Smoking Cessation.
- Diabetes Awareness/Education.
- Heart Health and Disease Prevention.
- Chronic Obstructive Pulmonary Disease (COPD).

TBT's disease management program is a free and confidential part of your TBT Plan. For more information or to sign up, call (855) 888-2144 or go to https://tbt.hmchealthworksco.com.

## Physician Benefits

Outpatient Physician and surgery benefits include covered services of Doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health, alcohol or chemical dependency treatment and other Providers.

Your TBT Plan pays a Coinsurance percentage of PPO Contract Rates for Outpatient benefits provided by PPO Providers. If you use Non-PPO Providers, your TBT Plan may pay a lower Coinsurance percentage of UCR charges. See your *Summary of Coverage* for Coinsurance applicable to your Plan. **Note:** See *No Surprises Act* on page 25.

### *Referral to a Non-PPO Physician by a PPO Provider for Outpatient Services*

If you are treated at a PPO facility by a Non-PPO Provider, Outpatient Physician benefits are paid at the same Coinsurance percentage as for PPO Outpatient benefits.

***Example:*** A PPO Physician operates on you at a PPO outpatient clinic, but the anesthesiologist is not a PPO Provider. If your Plan pays PPO Claims at 100% of the PPO rate and ordinarily pays Non-PPO Claims at 80% of UCR, the Plan will pay the Non-PPO anesthesiologist's bill without any Coinsurance payment by you, rather than at 80% of UCR, because the procedure was performed at a PPO facility.

### *Non-Emergency Services at a PPO Hospital*

If you are admitted for non-emergency surgery or treatment at a PPO Hospital but treated there by a Physician who is not in the PPO Network, the non-emergency Physician services are paid at the same Coinsurance percentage as PPO non-emergency services.

***Example:*** If your Plan pays PPO Claims at **100%** of the PPO rate and ordinarily pays Non-PPO Claims at **80%** of UCR, the Plan will pay the Non-PPO Physician's bill without cost sharing by you because you were treated for the non-emergency services or surgery at a PPO Hospital.

## Hospital Benefits

When you receive non-emergency services at a PPO Hospital, your Plan pays a percentage of the PPO-contracted rate. For inpatient services received in a Non-PPO Hospital when there is a PPO Hospital within a 30-mile radius of your home, benefits are reduced by **50%**. See your *Summary of Coverage* for the specific rates your TBT Plan will pay when you go to the Hospital.

***Pre-admission Certification* is required for all non-emergency stays.** You must notify Anthem Blue Cross of an emergency confinement as soon as possible following admission (and no later than **72 hours** after admission). **Failure to obtain Pre-admission Certification will result in a 10% reduction in benefits.**

### *A Few Exceptions*

There are situations when the percentage payable for inpatient benefits is the same at a Non-PPO Hospital as at a PPO Hospital:

1. **Emergency Services**—If you are treated in a Hospital emergency room at a Non-PPO Hospital for an Emergency, the Plan applies the same Coinsurance percentage to covered services as it does to PPO Hospital services.

2. **PPO Hospital Not Available Within 30 Miles of Your Home—** If there is no PPO Hospital within a 30-mile radius of your home, or if a PPO Hospital within 30 miles of your home cannot provide the services or treatment for your illness or injury, the Plan applies the same percentage to UCR as it applies to PPO Hospital services for Network rates.

   *Example:* You live more than 30 miles from any PPO Hospital and are hospitalized at a Non-PPO Hospital near your home. If your Plan pays PPO Claims at **100%** of the PPO rate for covered charges and pays Non-PPO Claims at **80%** of UCR for covered charges, because you live more than 30 miles from a PPO Hospital, the Plan will pay the Non-PPO Hospitalization at **100%** of UCR, rather than **80%**. **Note:** This is an example. See the enclosed *Summary of Coverage* for details related to your TBT Plan.

### *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 72 hours). Failure to obtain Pre-admission Certification will result in a **10%** reduction in benefits. Charges for non-certified Hospital days are not covered under your Plan (see *Hospital Requirements* on pages 26-28 for more information).

## Outpatient Services

Outpatient services are paid at a percentage of PPO rates in a PPO facility and at a percentage of UCR charges in a Non-PPO facility. See your *Summary of Coverage* for details about surgery and treatment of Accidental Injury within 24 hours. Under some TBT Plans, these services may not be subject to a Deductible.

### *What Are Outpatient Services?*

- Outpatient Hospital services may include services provided by a Hospital in an emergency room or clinic attached to a Hospital.
- Treatment at surgery centers or clinics, urgent care clinics and ambulatory centers, and
- Physician and surgery benefits, including covered services provided by x-ray centers, clinical laboratories and physical therapy centers.

### *Outpatient Surgery Rates*

See your *Summary of Coverage*.

## PPO Incentives

Just because an expense is covered does not mean it will be paid in full. When you are treated by PPO Providers, your out-of-pocket costs are lower. PPO Doctors and Hospitals charge reduced rates for their services, which helps keep costs down for you and the Plan. Be sure to check with Anthem Blue Cross at (888) 887-3725 before you seek treatment to confirm whether a Hospital, Doctor or other Provider currently participates in the PPO Network. **Note:** Non-California residents can verify that their Provider is in the PPO Network by calling the Anthem Blue Cross Blue Shield National Network at the number listed on page 91.

If you are treated at a Non-PPO facility or by a Non-PPO Provider and what you are billed is higher than UCR charges, you are responsible for paying the difference unless the service is protected by the "No Surprises Act" explained on this page.

The difference between the Provider's charge and the Allowed Amounts (including the higher Non-PPO Coinsurance percentage of the Allowed Amount that you are obligated to pay) is known as Balance Billing.

### *NO SURPRISES ACT*

*If you are treated at an out-of-network Hospital or urgent care center, you must generally pay more out of pocket than if treated in a PPO Hospital or urgent care center. The federal No Surprises Act provides that your out-of-pocket costs for the following out-of-network emergency Claims will not be greater than if you were treated in-network:*

1. *Emergency services.*
2. *Services provided by an **out-of-network Doctor** or other health care Provider at an **in-network** Hospital or urgent care center.*
3. *Air ambulance services.*

*For Claims subject to the No Surprises Act, the Plan's payment shall be applied to make what you and the Plan pay comparable to what would have been paid had the Claim been incurred in a PPO facility.*

*However, Non-PPO treatment that is not subject to the No Surprises Act will not be entitled to the protections explained above. These Claims will be paid as shown in your **Summary of Coverage**.*

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 will be reduced. In addition, Utilization Review is required for all Hospitalizations and other case management procedures also apply (see pages 26-28 and your *Summary of Coverage*).

### PPO Network for Non-California Residents

If you live outside California, the Indemnity Medical Option has a Network of Preferred Providers *outside* of California for Pre-admission Certification, except for alcoholism or chemical dependency. To locate the nearest PPO Hospital, you must call the Anthem Blue Cross Blue Shield National Network at (800) 810-2583 or use the "Find a Doctor" feature at www.bcbs.com. Or visit www.anthem.com and select your state.

Hospitalization in a Non-PPO facility for non-emergency services will likely result in your having to pay substantially more out of-pocket. Your Covered Expenses may be as much as **50%** less depending on your TBT Plan. See your *Summary of Coverage* for details.

## HOSPITAL REQUIREMENTS

### Pre-admission Certification

Pre-admission Certification is required before you are covered for any non-emergency Hospitalization. Make sure your Doctor's office staff calls Anthem Blue Cross before scheduling the Hospital stay. Failure to obtain Pre-admission Certification will result in a **10%** reduction in benefits. Charges for non-certified Hospital days are—depending on your TBT Plan—covered at a reduced percentage or not covered at all. Check your *Summary of Coverage* for details.

***IMPORTANT NOTE: If Admitted for a Long Hospital Stay***

- *If your Hospitalization might need be extended, your Doctor must contact Anthem Blue Cross to request Pre-admission Certification for any additional days and confirm that the entire Hospitalization will be covered.*
- *Pre-admission Certification does not mean that your eligibility will be extended. If your coverage ends after you are admitted to the Hospital, you or your family should call the TBT Plan Administration Office to review how you can continue coverage by self-payment. For example, you may be able to apply for an extension of coverage by filling out and submitting required forms to TBT. See FMLA on page 11 and COBRA (starting on page 14).*

In an emergency, Anthem Blue Cross must be notified as soon as possible following admission (and no later than 72 hours after admission). The Hospital or Physician must call Anthem Blue Cross at (800) 274-7767. Once notified, the registered nurse coordinators and Doctors at Anthem Blue Cross 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, you must notify the Teamsters Assistance Program (TAP) to pre-certify and oversee Hospitalization. Call TAP at (800) 253-TEAM or (510) 562-3600 for Pre-admission Certification.

If you live in the Central Valley, or are a member of Teamsters Locals 87, 137, 150, 386, 431, 439, 533 or 948, the Teamsters Alcohol/Drug Rehabilitation Program (TARP), rather than TAP, oversees Hospitalization due to alcohol or chemical dependency treatment. Call TARP at (800) 522-8277 or (209) 572-6966.

The best time for you to notify Anthem Blue Cross (or TAP or TARP, 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 Anthem Blue Cross. If you have not received a notice, you should verify that Pre-admission Certification has been conducted before going to the Hospital. It is a good idea to check with Anthem Blue Cross (or TAP or TARP, if applicable) in advance.

Remember, if Anthem Blue Cross Life and Health Company (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 Anthem Blue Cross. Your Doctor is contacted to confirm the need for Hospitalization. Anthem Blue Cross 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.**

**Even though Anthem Blue Cross must certify Medical Necessity during the Hospital stay, that certification does not guarantee that you are eligible for benefits.** For the Hospital stay to be covered, you must remain eligible for Plan coverage during the entire Hospitalization.

### *Utilization Review When You Need to be Hospitalized—Pre-admission Certification and Concurrent Review*

**Pre-admission Certification is required for all non-emergency Hospitalizations.** This process assures that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or other inpatient health care facility for Surgery and other health care services are Medically Necessary. During the Pre-admission Certification process, Anthem Blue Cross can also help you find locations for PPO Providers.

## How Pre-admission Certification Works

Your Provider must call Anthem Blue Cross at the number listed on page 91 at least seven days before a Hospital admission. When your Doctor calls Anthem Blue Cross, he/she will need to provide:

- Your name and Social Security number.
- The patient's name, address and birth date.
- The names, addresses and phone numbers of the Provider and/or the Hospital or health care facility.
- The reason for the proposed Hospitalization or health care service, and
- The date of the proposed Hospitalization or health care service.

Anthem Blue Cross will review the information provided and will advise your Health Care Provider, the Hospital and TBT whether the proposed admission or inpatient health care services have been pre-certified. Any adverse review determination will be communicated to you and your Health Care Provider in writing.

If you do not receive the pre-certified service within 60 days of the date the service was pre-certified, or if the nature of the service that was pre-certified has changed, a new Pre-admission Certification must be obtained. **If there is no Hospital Pre-admission Certification, your Claim for being hospitalized will be denied.**

*Even though your Provider should call to request Pre-admission Certification, be sure to follow up and make sure Pre-admission Certification was completed.*

***REMEMBER—IT IS YOUR RESPONSIBILITY TO MAKE SURE YOUR PROPOSED ADMISSION OR OTHER HEALTH CARE SERVICES ARE PRE-CERTIFIED BY ANTHEM BLUE CROSS.***

**Pre-admission Certification does not guarantee payment of benefits. You must be eligible at the time of *both* the Pre-admission Certification *and* the Hospitalization.**

The purpose of Hospital Pre-admission Certification is to ensure that you are receiving care in the most appropriate setting. In some cases, a lower cost alternative to the treatment or service you are considering may be appropriate.

For example, some routine surgical procedures may be safely performed on an Outpatient basis when you may not need to be hospitalized to receive effective treatment. However, Pre-admission Certification is not intended to diagnose or treat health conditions, validate eligibility for coverage or guarantee payment of Plan benefits.

With respect to the administration of this Plan, the Board of Trustees and Anthem Blue Cross Life and Health (currently the Plan's Review Organization) are *not* engaged in the practice of medicine; none of them take responsibility either for the quality of health care services actually provided, even if the services have been pre-certified by Anthem Blue Cross as Medically Necessary, or for the results if the patient chooses not to receive services that were not certified as Medically Necessary.

## Emergency Hospitalization

If an emergency requires Hospitalization, there may be no time to contact Anthem Blue Cross before you are admitted. If this happens, **Anthem Blue Cross must be notified of the Hospital admission within 72 hours of the admission.** You, your health care Provider, the Hospital or a family member can make this phone call. The call enables Anthem Blue Cross to assist you with your discharge plans, determine the need for continued medical services, advise your health care Providers of the benefits available and offer recommendations, options and alternatives for your continued medical care.

There is no requirement to preauthorize a visit to a Hospital-based emergency room (ER) visit.

### Concurrent (Continued Stay) Review

While you are in the Hospital, **Concurrent Review** is also required to monitor required services and related charges—even if the admission was due to an emergency. Concurrent Review ensures that the Hospital stay is Medically Necessary and appropriate in length.

If while you are in the Hospital, your Doctor concludes that your inpatient stay needs to be longer than the Plan had certified before you were admitted, your Doctor must notify Anthem Blue Cross in advance. **If Anthem Blue Cross determines that any in-Hospital days are not Medically Necessary, these days are not covered.**

#### *How Concurrent (Continued Stay) Review Works*

1. When you are receiving medical services in a Hospital or other inpatient health care facility, Anthem Blue Cross will monitor your stay by contacting your health care Providers to assure that continuation of medical services in the health care facility is Medically Necessary and to help coordinate your medical care with benefits available under the Plan.
2. Concurrent Review may include such services as coordinating Home Health Care or Durable Medical Equipment, assisting with discharge plans, determining the need for continued medical services or advising your health care Providers of various options and alternatives for your medical care available under your Plan.
3. If at any point your stay or services are found NOT to be Medically Necessary, and that care could be safely and effectively delivered in another environment, such as through Home Health or in another type of health care facility, you and your health care Provider will be notified. This does not mean that you must leave the Hospital or stop receiving services. **But if you choose to stay or continue services, all expenses incurred after the notification are your responsibility.** If it is determined that your Hospital stay or services were not Medically Necessary, **benefits will not be paid for any related Hospital, medical or surgical expenses.**

### Case Management

Anthem Blue Cross also reviews ***Outpatient*** services in light of the patient's diagnosis and health care needs.

In some cases, a patient's needs may be met as well or better through an *alternative* to an acute care Hospital confinement. Such treatment plans could include Home Health Care, Hospice Services or Skilled Nursing Facility care.

Anthem Blue Cross 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. **However, the Plan covers alternative treatment plans only when they have been pre-certified by Anthem Blue Cross.**

### Appealing a Utilization Review Determination (Appeals Process)

You may appeal any Adverse Decision made during the Pre-admission Certification, Concurrent Review or Case Management processes described in this *Guide*. To appeal a denied Pre-Service, Urgent, Concurrent Care or Post-Service Claim or bill, see pages 58-65.

Pre-admission Certification is not intended to diagnose or treat health conditions, validate eligibility for coverage or guarantee payment of Plan benefits. With respect to the administration of this Plan, the Board of Trustees and the Plan's current Medical Review Organization are *not* engaged in the practice of medicine. Neither the Board nor the Medical Review Organization takes responsibility for the quality of health care services actually provided, even if the services have been certified by a Medical Review Organization as Medically Necessary, or for the results if the patient chooses not to receive services that have not been certified as Medically Necessary.

## COVERED EXPENSES

### Hospital Benefits

Inpatient benefits provided by a PPO Hospital are paid at a percentage of covered charges explained in your *Summary of Coverage* until you meet your annual Out-of-Pocket Maximum, and at **100%** thereafter. Check with the Anthem Blue Cross PPO Network at (888) 887-3725 to make sure you are using PPO Providers and getting your Plan's maximum benefits. Inpatient benefits provided by a Non-PPO Hospital are paid at your Plan's percentage of UCR as explained in your *Summary of Coverage*.

If you or your covered Dependents are admitted to a PPO- or Non-PPO Hospital for a covered illness or injury, the Plan pays room and board charges up to the Hospital's standard charge for a semi-private room. Coverage is only provided for the number of days in the Hospital that Anthem Blue Cross has determined to be Medically Necessary.

## Inpatient Supplies and Services

The Plan pays a percentage of the PPO Contract Rates at a PPO Hospital until you reach your Out-of-Pocket Maximum or a lower percentage of Usual, Customary and Reasonable (UCR) charges at a Non-PPO Hospital for Medically Necessary inpatient supplies and services.

## 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 Skilled Nursing Facility. See *Skilled Nursing Facility* benefits on page 30 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.

## Chiropractic Treatment Benefits (see page 31)

## Alcohol or Chemical Dependency Treatment Benefits (see page 32)

## Surgery and Doctors' Visits

The Plan covers the following services up to your Plan's Coinsurance percentage listed in your *Summary of Coverage*:

1. Medically Necessary professional services.
2. Services of one or more assistant surgeons, but not to exceed the percentage of the maximum Covered Expenses for the Surgery (Physician Services) described in your *Summary of Coverage*.
3. Outpatient psychotherapy and psychometric testing (see *Mental Health Services* on page 30).

## Other Covered Expenses

The following services are also covered up to the Plan's Coinsurance percentages. 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 of a covered Hospital or Skilled Nursing Facility stay. Additional Home Health Care benefits may be covered (if pre-certified by Anthem Blue Cross).
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 Anthem Blue Cross) of braces and Durable Medical Equipment for therapeutic treatment.
8. Artificial limbs, eyes or other prosthesis (including surgical bra) required to replace natural limbs, eyes or other parts of the anatomy.
9. Foot orthotics.
10. Contraceptive implants and devices.
11. Vaccinations described in your *Summary of Coverage* and *Preventive Care and Wellness Benefits* supplement to this *Guide*, including vaccinations recommended by the Centers for Disease Control and the American College of Obstetrics and Gynecology.
12. Hospice Services.
13. Some medical services (including physical therapy and occupational therapy) are covered only when Medically Necessary. However, the referring Physician must submit a written treatment plan to the TBT Plan Administration Office for approval before treatment may begin. The treatment plan must specify the frequency and duration of services. Continued treatment is subject to ongoing medical review by the TBT Plan Administration Office.
14. Cochlear implants with required preauthorization. Note that the Plan excludes coverage for hearing aids—see page 35.
15. Wig for temporary or permanent hair loss caused specifically by illness or injury limited to your TBT Plan's benefit amount (see your *Summary of Coverage*). Naturally occurring hair loss is not considered an illness or injury for this benefit.

16. Diabetic services, including equipment, supplies, nutritional counseling and diabetic self-management training programs, if Medically Necessary.
17. Rehabilitation or speech therapy services are covered when Medically Necessary and must be provided by a licensed speech therapist, licensed audiologist, licensed physical therapist, respiratory or inhalation therapist or cardiac rehabilitation program. However, the referring Physician must submit a written treatment plan to the TBT Plan Administration Office for approval before treatment may begin. The treatment plan must specify the frequency and duration of services. Continued treatment is subject to ongoing medical review by the TBT Plan Administration Office.
18. Private duty nursing, if Medically Necessary, up to your Plan's maximum limits explained in your *Summary of Coverage*. Custodial Care is not covered.
19. Some medical services (such as acupuncture) are covered when Medically Necessary and must also be preauthorized by the TBT Plan Administration Office. An acupuncture referral is required from the licensed Physician who must provide a written treatment plan that specifies the reasons for the services, frequency and duration. Continued acupuncture treatment is also subject to ongoing medical review by the TBT Plan Administration Office.

**Note:** The Plan does not pay for routine treatment where medical review shows that ongoing treatment has not improved the condition and/or is not Medically Necessary.

## Other Medical Benefits

### Preventive Care Benefits

In-network PPO Preventive Care benefits are provided without any cost-sharing (meaning the Plan pays **100%** of the cost and you do not need to pay Coinsurance, a Copayment or meet your Deductible).

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, diabetic instruction and immunizations are covered (see *Preventive Care Services* on page 23 and your *Summary of Coverage*).

Covered Preventive Care benefits are described in a *Preventive Care and Wellness Benefits* supplement to this *Guide*. Preventive Care benefits from a Non-PPO Provider are generally paid at **90%** of the Usual, Customary and Reasonable (UCR) amount.

### Skilled Nursing Facility

Room and board in a Skilled Nursing Facility (see definition, page 86) is limited to the first 60 days as a registered inpatient, as long as this treatment plan is pre-certified by Anthem Blue Cross. Custodial Care is not covered.

The Skilled Nursing Facility stay must begin within seven days after Hospitalization, unless alternative care is pre-certified by Anthem Blue Cross (see *Case Management* on page 28).

The Plan will NOT pay benefits for Skilled Nursing Facility room and board higher than the facility's standard charge for a semi-private room. No benefits are payable for Custodial Care or for services that have not been pre-certified by Anthem Blue Cross.

### Mental Health Services

Inpatient and Outpatient mental health services are covered the same way as any physical illness. *Pre-admission Certification*, *Utilization Review, Concurrent Review* and *Case Management* requirements also apply as explained on pages 26-28.

### Gene Therapy Coverage

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. This technique modifies a person's genes to treat or cure disease and can work by several mechanisms:

- Replacing a disease-causing gene with a healthy copy of the gene,
- Inactivating a disease-causing gene that is not functioning properly, or
- Introducing a new or modified gene into the body to help treat a disease.

Gene therapy is covered under the medical benefit (not the pharmacy benefit) on the same basis as other medical benefits. To be covered, the therapy must be FDA-approved and used for the approved indication. Coverage of off-label and Experimental therapies is excluded. Prior authorization through Anthem Blue Cross is required. Participants must meet Anthem's internal clinical guidelines for the therapy. **Gene therapy may only be administered at a participating PPO Hospital or clinic.**

### *LiveHealth Online (Telemedicine Benefit)*

Your TBT Plan covers telemedicine visits when scheduled through the Indemnity Medical Plan's *LiveHealth Online* telemedicine service—without needing to first satisfy your Plan's Deductible or any Copayment.

When you need to see a Doctor, you may use *LiveHealth Online* 24/7 to schedule a video or phone visit with a board-certified Doctor using your smartphone, tablet or computer.

Sign up at www.livehealthonline.com or download their free mobile app. When you set up your account or make appointments, you will be asked questions to help representatives confirm you are enrolled in your TBT Plan's Indemnity Medical Option.

Phone or video consultations with your regular Doctor (or that are not scheduled through *LiveHealth Online*) are subject to your Plan's Deductible and Copayments.

#### *Benefits of Video Doctor Visits*

*LiveHealth Online* visits are like seeing your Doctor face-to-face, but by using your phone or computer camera in the privacy of your home or another location.

- Telemedicine visits are an excellent way to get medical care when your usual Doctors are not available.
- Board-certified Doctors can diagnose or treat colds and flu, simple infections and many medical conditions.
- The Doctor can send prescriptions to the pharmacy you choose, if needed.
- If you're feeling stressed, worried or having a tough time, you can schedule a *LiveHealth Online* appointment to talk with a licensed therapist or psychologist.

Video Doctor visits are meant to complement face-to-face visits with your regular Doctor or medical specialists and are available for many types of care. However, in an emergency, **call 9-1-1** or get to the nearest Hospital emergency room or urgent care center.

### *Autism Treatment*

Treatment for Autism Spectrum Disorder (ASD), including Applied Behavior Analysis (ABA) and Applied Behavior Therapy (ABT), is covered subject to the same conditions that apply to other kinds of Outpatient therapy, including Deductibles, Copayments, Coinsurance, review for Medical Necessity and other medical management.

**Note: If your Autism Provider does not participate in the Anthem Blue Cross PPO Network, your out-of-pocket costs are higher.**

### *Chiropractic Treatment Benefits*

The Plan pays for Medically Necessary Chiropractic Treatment provided by a licensed Doctor of Chiropractic medicine up to the per visit Chiropractic Treatment maximum listed in your *Summary of Coverage*.

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

### *Coverage of Treatment of Gender Dysphoria*

Gender dysphoria is the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. The Plan covers Medically Necessary treatment for Plan participants and Dependents who have been diagnosed with gender dysphoria, subject to Utilization Review and Case Management by Anthem Blue Cross.

The following treatment is covered:

- Hormone therapy.
- Sex reassignment or gender affirmation surgery—where Medically Necessary and where gender dysphoria cannot be relieved through hormone therapy alone to change primary and/or secondary sex characteristics (such as breasts/chest, external and/or internal genitalia) for covered individuals over the age of 18 who have lived for at least 12 continuous months in the gender role that is congruent with their gender identity.
- Psychotherapy—including assessment of gender dysphoria, assessment of options for gender identity and expression and possible medical/surgical intervention, and assessment of eligibility and referral for hormone therapy and/or surgery, and
- Coverage of puberty-suppressing medications where Medically Necessary for Children and adolescents. Partially reversible and irreversible medical and surgical interventions for individuals under age 18 are subject to review by Anthem Blue Cross on a case-by-case basis.

The Plan generally excludes Cosmetic treatment (as explained on page 34). Therefore, coverage of surgical treatment for gender dysphoria does not include Cosmetic services, including services used to improve the gender-specific appearance of an individual who has undergone or is planning to undergo sex reassignment or gender affirmation surgery. Non-covered cosmetic procedures include breast augmentation, electrolysis, facial bone reconstruction, facial implants, jaw reduction, liposuction, pectoral implants, voice modification surgery and voice therapy.

### *Alcohol or Chemical Dependency Treatment Benefits*

Inpatient and Outpatient alcohol or chemical dependency services are covered the same way as any physical illness. Pre-admission Certification, Utilization Review, Concurrent Review and Case Management requirements also apply (as explained on pages 26-28).

Drug and alcohol dependency assessment and referral is available to you and your Dependents through the Teamsters Assistance Program (TAP) if you live or work in the Greater Bay Area—or through the Teamsters Alcohol Rehabilitation Program (TARP) if you live or work in the Central Valley. Both TAP and TARP are independent of the Fund. TAP and TARP contact information is listed on page 91.

Alcohol or Chemical Dependency Treatment benefits are coordinated with medical benefits, so these benefits accumulate to the same overall medical benefit Deductible amounts.

Plan benefits are intended to comply with federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations. Coverage for mental health and alcohol or chemical dependency treatment (sometimes collectively referred to as behavioral health services) should be no more restrictive than coverage for other medical conditions. Indemnity Medical Claims for mental health and alcohol or chemical dependency treatment are accumulated to meet the same medical benefit Deductible and Out-of-Pocket Limit applicable to Claims for other types of medical care. If the information in this *Guide* conflicts with newly released government regulations affecting the coverage of Mental Health and Alcohol or Chemical Dependency services, this Plan will comply with the new requirements as of the date required.

*Provider Network:* TAP and TARP provide a Network of contracted Alcohol or Chemical Dependency Treatment professionals and facilities in California. These contracted Providers extend a discount to you for covered Alcohol or Chemical Dependency services. TAP or TARP services are described on this page and page 33.

**Note: If you require Alcohol or Chemical Dependency Treatment outside of California, contact TAP or TARP to arrange coverage or be advised regarding your location's Network treatment facilities and Providers.**

### *Inpatient Treatment*

Treatment at an approved inpatient residential detoxification and treatment facility or a licensed Chemical Dependency Recovery Hospital (CDRH) must be preauthorized and monitored by TAP or TARP.

Preauthorization by TAP or TARP is required for all non-emergency inpatient residential treatment stays and within 72 hours of an emergency admission. **Failure to preauthorize will result in a penalty of 10% of covered charges.**

### *Outpatient Treatment*

Preauthorization by TAP or TARP for all Outpatient treatment is highly recommended.

### *Alcohol or Chemical Dependency Treatment Exclusions (Services That Are Not Covered)*

The following services, supplies and expenses are excluded under the Plan's Alcohol or Chemical Dependency Treatment benefits. The Board of Trustees or its designee has discretionary authority to determine the applicability of these exclusions and the other terms of the benefits and entitlement to Plan benefits in accordance with the terms of the Plan.

**Note:** Read these exclusions carefully before seeking counseling or treatment. Some services and treatments that are not covered by the Alcohol or Chemical Dependency Treatment benefits described here may be covered under other benefits described in this Indemnity Medical section.

The following services are NOT covered:

1. Services that exceed what has been preauthorized by TAP or TARP.
2. Treatment at a California-based facility that is not approved by TAP or TARP—or that is not certified by the California Department of Health Care Services and by CARF (the Commission on Accreditation if Rehabilitation Facilities).
3. Treatment outside California at a non-TAP or non-TARP-approved facility that is not certified by either CARF (the Commission on Accreditation of Rehabilitation Facilities) or JCAHO (the Joint Commission on Accreditation of Healthcare Organizations).
4. Private Hospital rooms and private duty nursing unless determined to be Medically Necessary.

5. Coverage for services within a treatment plan designed exclusively for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation or education for personal or professional growth.
6. Health care services, treatment or supplies determined to be Experimental Treatment (as defined on page 83).
7. Biofeedback treatment, hypnotherapy or acupuncture, unless preauthorized by TAP or TARP based upon Medical Necessity.
8. Expenses for a boot camp-type program, boarding school, military school, foster home or group home care (or any other facility combining Alcohol or Chemical Dependency Treatment and general education).

### Stop-Smoking Benefits

HMO participants may be eligible for the stop-smoking benefits explained in this *Guide*, in addition to any stop-smoking benefits available through the HMO.

#### *What the Plan Covers*

Your TBT Plan covers (without cost-sharing) screening for tobacco use and up to two tobacco cessation attempts per year. A "tobacco cessation attempt" includes coverage for:

- Four tobacco cessation counseling sessions of at least 10 minutes each (including phone counseling, group counseling and individual counseling) without prior authorization, and
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. **Note:** The Plan will only reimburse you for these treatments if they are part of a prescribed treatment plan.

#### *Doctor's Office Visit*

An office visit related to use of nicotine patches is reimbursed in the same way as other Doctors' office visits for Preventive Care services as explained on pages 23-24 and in the supplement to this *Guide* called *Preventive Care and Wellness Benefits*.

### Coverage of Organ and Tissue Transplants

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** for the organ or tissue recipient or the organ or tissue donor:

When the transplant *recipient* is covered under a TBT Plan and the *donor* is not covered under a TBT Plan, benefits for the donor are reduced by any amounts paid or payable by that donor's own coverage. Covered Expenses for the donor, including donor testing and donor search, are limited to expenses incurred for Medically Necessary services only. Reasonable charges for services incidental to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

When the transplant *recipient* is *not* a covered person under a TBT Plan, and the *donor* is covered under a TBT Plan, 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.

When the transplant recipient and the donor are both covered under a TBT Plan, benefits are provided in keeping with the provisions of their respective TBT Plans.

## WHAT IS NOT COVERED

### Limitations and Exclusions

The Indemnity Medical Option covers treatment, services or supplies that are (1) Plan benefits as described in this *Guide* and your Plan notices, (2) Medically Necessary and (3) 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. 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.
5. Cosmetic surgery, unless required (1) to repair or alleviate damage caused by an Accident, 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. Excluded Cosmetic Surgery or Treatment includes, but is not limited to:
   - Removal of tattoos.
   - Breast augmentation or mastopexy for Cosmetic purposes (except the Plan covers Medically Necessary reconstructive services, including after a mastectomy).
   - Breast reduction for Cosmetic purposes.
   - Removal of redundant skin, elimination of redundant skin of the abdomen, abdominoplasty.
   - Surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance.
   - Treatment of varicose veins.
   - Skin resurfacing, chemical skin peel, Cosmetic skin products such as restylane and renova, collagen injections.
   - Face/forehead/brow/eyelid/neck lift, upper eyelid blepharoplasty, nose/lip/cheek/malar/chin enhancement, reduction or implant, facial bone reduction.
   - Calf/buttocks/pectoral implants.
   - Liposuction body contouring.
   - Reduction thyroid chondroplasty.
   - Voice modification surgery (laryngoplasty or shortening of the vocal cords, voice therapy/ voice lessons).
   - Drugs for hair loss, hair growth, hair removal, hair implantation.
   - Other medical or surgical treatment intended to restore or improve physical appearance, as determined by the TBT Plan Administration Office or its designee.

   Cosmetic Surgery does not become reconstructive Surgery if desired for psychological reasons; however, the Plan covers Medically Necessary Reconstructive Services.
6. Dental services and supplies unless the expense is necessary for repair or alleviation of damage to natural teeth caused by an Accident.
7. Expenses incurred for prescription Drugs and prescription medicines except (1) while hospitalized or (2) for Specialty Drugs that must be administered by a Physician on an Outpatient basis.
8. Drugs and medicines dispensed in a Doctor's office except Specialty Drugs that must be administered by a Physician on an Outpatient basis.
9. Nutritional counseling except when prescribed to treat a specific medical condition (including a diagnosis of obesity) and provided by a licensed dietitian.
10. 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; however, the Plan covers participation in clinical trials subject to preauthorization. If the Plan authorizes participation in a clinical trial, the Plan will cover routine costs associated with this trial. This means that routine costs, services and supplies are payable during the time the eligible individual is participating in the clinical trial and the Plan's standard benefits apply. (See the definition of *"Experimental"* on page 83 for more information.)
11. Any charge related to the treatment of infertility, including but not limited to artificial insemination, in vitro fertilization, reversal of tubal ligation or vasectomy or any form of assisted reproductive technology.
12. Intentionally self-inflicted injuries or medical conditions, unless the injury results from a medical, mental health or Alcohol or Chemical Dependency condition.
13. Conditions caused by or related to an act of war, armed invasion or aggression.
14. Any Accidental 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 68.)

15. 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).
16. 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.
17. Charges that are higher than would otherwise be billed for the same care if benefits were not provided under the Plan. The Plan does not pay expenses that it is not obligated to pay (for example, expenses covered by an HMO for which no charge would otherwise be made to the patient or which the patient is not legally obligated to pay).
18. Any charges that would not be made in the absence of this coverage.
19. Charges for itemized reports or itemized billing, except when requested by the Plan.
20. Charges for failure to keep a scheduled appointment.
21. Charges for services incurred before coverage was effective.
22. Services that are custodial in nature, rather than professional medical services prescribed by a Doctor. Custodial Care is non-medical care that helps individuals with their daily basic needs, such as eating, going to the toilet and bathing.
23. Any services provided by a family member or someone who lives in your home.
24. Biofeedback, hypnotism and hypnotherapy.
25. Purchase of Durable Medical Equipment unless such purchase is determined appropriate, cost-effective and pre-certified by Anthem Blue Cross.
26. 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.
27. Vitamins, including covered injections, even when prescribed, except for:
    - Folic acid supplementation
    - Fluoride supplementation
    - Iron supplements, and
    - Vitamin D

    or unless the vitamin is Medically Necessary as determined by the Plan or as described as covered elsewhere in this *Guide*.
28. Sales tax.
29. Ambulance, including air ambulance, when not appropriate for the level of medical treatment required or solely for convenience.
30. Waterbeds or flotation beds.
31. 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.
32. Support stockings, except for the initial pair prescribed by a Doctor following surgery.
33. Orthotics, except for the initial pair prescribed by a Doctor, or replacement orthotics for Dependents under age 19 if Medically Necessary or due to growth.
34. Eyeglasses, lenses and eye refractions. (However, see your *Vision Care Benefits* beginning on page 48.)
35. Radial Keratotomy (RK) and any other form of eye surgery intended to correct nearsightedness or astigmatism.
36. Hearing aids and related expenses; however, Cochlear Implants are covered.
37. Food or infant formula. Enteral or parenteral nutrition prescribed by a Doctor, and administered by a feeding tube (or similar method) or intravenously, is covered by the Plan.

### *OPEN ENROLLMENT*

*After your initial medical option election, you may change your medical and/or dental options once every 12 months. Each time you change an option, a new 12-month Open Enrollment 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.*

*See pages 10-11 for Open Enrollment details.* *Also check the* ***Comparison of Medical Benefits*** *for details about your Plan's medical options.* ***Note:*** *Your Plan's HMO options provide communication brochures and an* ***Evidence of Coverage*** *to explain their benefit coverage and enrollment requirements. You can request these materials by calling the HMO at the phone number printed in the TBT Providers List on page 91.*

# Your Prescription Drug Benefits

Your prescription drug benefits are administered by Anthem CarelonRx, which is the "Pharmacy Benefit Manager" (PBM). To get the most from your coverage, you should present your prescription drug ID card at a participating pharmacy. The PBM Network includes most retail pharmacies and drugstore chains, and you can obtain maintenance medications from the Anthem CarelonRx mail order pharmacy. This is the pharmacy benefits company for Anthem Blue Cross, the company that is also responsible for the Indemnity Medical Plan's Blue Cross of California PPO Network.

## 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 *When Your Coverage Begins* on page 4).

### DRUG BENEFITS IF YOU ARE IN THE HMO

***Kaiser Participants:*** *For most TBT Plans, Anthem CarelonRx is the Prescription Drug Provider if you are enrolled in Kaiser. However, for TBT Plans I-A, III-A, V-A or VI, prescription drug coverage for Kaiser participants is* ***only provided through Kaiser****. The Kaiser formulary will also apply.*

***Anthem Blue Cross HMO Participants:*** *Anthem CarelonRx is the Prescription Drug Provider for all Plan participants enrolled in the Anthem Blue Cross HMO. Your prescription drug coverage is* ***only provided through Anthem CarelonRx*** *(as explained in this section).*

***Note:*** *To confirm where to submit prescription drug Claims, HMO participants should contact their HMO at the phone number listed on page 91.*

## TBT Pharmacy Benefit Manager (PBM)

TBT uses a Pharmacy Benefit Manager (PBM) that administers the retail pharmacy Network and mail service program for Plan participants. The current PBM is Anthem CarelonRx. (If the Plan changes PBMs in the future, you will be notified in writing of the change.)

## Prescription Drug ID Card and Welcome Packet

When the TBT Plan Administration Office receives your *TBT Enrollment Form* and sends your eligibility status to Anthem CarelonRx, this triggers a PBM welcome packet being mailed to your home (including program information, prescription drug ID cards, mail service and formulary details).

Your prescription drug ID card lists your name only 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. You may order an additional prescription drug ID card for a covered child who may live away from home by calling Anthem CarelonRx at the number listed on page 91.

## Anthem CarelonRx Account

Visit the Anthem Blue Cross website at www.anthem.com/ca to set up your individual Anthem CarelonRx account to download ID cards, see your coverage, order prescription refills or find a participating retail pharmacy. You can also contact Anthem CarelonRx at the number listed on page 91.

## What is Covered

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), (4) covered under the Anthem National Direct Formulary, and (5) not on the exclusion list called *What is Not Covered Under the Outpatient Prescription Drug Benefit* on pages 40-41.

Also review your *Summary of Coverage* for information about Copayments (if any) that apply to your prescription drug benefits.

## Anthem National Direct Formulary

Your Plan currently has a "**formulary**" of preferred or non-preferred Drugs called the Anthem National Direct Formulary maintained by Anthem CarelonRx. If you have formulary questions, call Anthem CarelonRx customer service at (833) 308-3034.

### *What determines what items are on or off the formulary's covered Drugs?*

All Drugs must be fully approved by the FDA and not excluded under the heading *What is Not Covered Under the Outpatient Prescription Drug Benefit* on pages 40-41. However, not all FDA-approved Drugs are covered.

What is covered under the Anthem CarelonRx Formulary is determined by a committee of Doctors and Pharmacists who base their decisions on the safety, quality and cost-effectiveness of a Drug.

## Use of 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 (see your *Summary of Coverage* for details).

## Contraceptive Coverage

FDA-approved contraceptives for women are paid at **100%** with no cost-sharing for Generic contraceptives submitted with a Physician's prescription and at an in-network retail pharmacy or mail order location. There is no charge for brand name prescription contraceptive Drugs but only if a Generic contraceptive is unavailable or medically inappropriate (as determined by the patient's Physician) and if also preauthorized by Anthem CarelonRx. Call Anthem CarelonRx at the phone number listed on page 91 to ask whether a particular contraceptive will be covered with no Copayment.

## Mail Service Program

If you need to fill a prescription for a Drug that you will take for three months or longer, you may use the mail service program but are not required to do so.

Mail service is a convenient way to order prescription drugs by phone or online and have them sent directly to your door. This is especially convenient if you need "maintenance drugs" that are typically taken on a regular basis for chronic or long-term conditions (such as diabetes, high blood pressure, cholesterol and asthma).

The same restrictions and exclusions that apply to the retail prescription drug program also apply to the mail service program. If you need a mail service form or information, call Anthem CarelonRx at the number shown on page 91.

**REMINDER**

*Some Drugs require your prescribing Doctor to obtain preauthorization from Anthem CarelonRx before they will be covered. If you are not sure whether an item is covered or requires preauthorization, call Anthem CarelonRx at the number listed on* ***page 91****.*

## Medications Requiring Preauthorization

Certain medications (such as these listed below) require preauthorization by Anthem CarelonRx:

- Opioids (including but not limited to fentanyl, oxycodone, hydrocodone, codeine and morphine).
- Non-Formulary Drugs.
- Specialty Drugs.
- Certain injectable Drugs.

## Preauthorization Process

When you fill your prescription, your Pharmacist will explain whether the PBM billing program requires preauthorization for your medication. Your Doctor must call Anthem CarelonRx Customer Service at (833) 308-3034 to request preauthorization.

## Specialty Drugs Pharmacy—Accredo

Specialty pharmaceuticals are new or expensive medications that may require special storage, handling, administration and education. They require preauthorization, are limited to a 30-day supply and must be processed through a special pharmacy called "Accredo." Your Doctor must call Anthem CarelonRx Customer Service at (833) 308-3034 to request a Specialty Drug preauthorization. Anthem CarelonRx will coordinate the preauthorization process with the Accredo pharmacy that will contact you to make delivery arrangements.

### *What is a Specialty Drug?*

Medications which have ***at least three*** of the following characteristics:

- Biotechnology products.
- FDA-designated orphan Drugs or ultra-orphan Drugs. ("Orphan" Drugs are used to treat rare diseases.)
- Any formulation of a Drug that is high cost as defined by the Plan's established procedures such as:
  - Ingredient Cost (IC) is greater than the Plan-approved monthly cost for either a medical or prescription Claim based on normal dosing.
  - Estimated IC is greater than the Plan-approved monthly cost for either a medical or prescription Claim based on FDA-approved recommended dosing.
- Requires special storage control or other specific shipping or handling requirements.
- Infusion or health care-administered injectable (which is professionally administered by a health care professional or in a health care setting).
- Therapy requires management and/or care coordination by a health care Provider specializing in treating the patient's condition.
- Requires focused, in-depth patient education and/or adherence monitoring and/or side effect management and/or injection preparation/administration education. The medication may have REMS programs ("Risk Evaluation and Mitigation Strategy" applicable to Drugs with possible severe side effects) requiring this level of clinical oversight beyond the standard REMS program medication guide requirements.
- Managed as part of an existing specialty therapeutic program.

*AND*

a medication which does ***not*** meet any of the following characteristics:

- Requires nuclear pharmacy sourcing.
- Preventive immunizations (such as influenza, DTP).
- Administration is allowed only in the inpatient setting.

#### *REMINDER*

*If your Drug requires preauthorization, your Doctor can call Anthem CarelonRx* ***at the number shown on page 91****. Once your Doctor's preauthorization request is submitted and reviewed, Anthem CarelonRx will notify you and your Doctor. If approved, Anthem CarelonRx will update its system to allow the prescription to be filled. If denied, Anthem CarelonRx will send you and your Doctor a notice providing the reason for the denial and outlining the appeals process.*

## Patient Care Coordinator

Since Specialty injectables and other specialty pharmaceuticals are limited to a 30-day supply, a Patient Care Coordinator will contact you to refill your prescription before it runs out.

#### *PREAUTHORIZATION PROCESS FOR SPECIALTY DRUGS*

- *Anthem CarelonRx will review the preauthorization request and inform your Doctor whether the Specialty Drug has been approved. You and your Doctor will be notified by Anthem CarelonRx.*
- *Once the preauthorization request has been approved, Anthem CarelonRx will contact you or your Physician's office to coordinate the delivery to your Doctor—or through mail order delivery to you—and collect any Copayment.* ***Specialty Drugs will not be available at a retail pharmacy.***
- *All Specialty Drug prescriptions will be limited to a 30-day supply. To avoid disruption to treatment, you will be contacted by Accredo to schedule refills before you run out.*

## Questions

If you have questions about the Specialty Pharmacy Program or covered injectable medicines you are taking, contact Anthem CarelonRx at the number listed on page 91. If you have other questions or need help, contact the TBT Plan Administration Office and ask for the Customer Service Unit.

### *Specialty Pharmacy Customer Service*

If you have questions regarding the Specialty Pharmacy program, contact Accredo at the number shown on page 91.

### *What happens if my Doctor has submitted the preauthorization request/form and the request is denied?*

You and your prescribing Physician will receive a denial notice from Accredo or Anthem CarelonRx. You must follow the procedures provided with the denial notice if you submit an appeal to the Anthem CarelonRx appeals department.

## Other Drugs that Require Preauthorization

Because of their cost, possible side effects and potential for abuse, in addition to Specialty Drugs, Opioids (including but not limited to fentanyl and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine and morphine), and Drugs prescribed for purposes other than their normal purpose, will not be covered unless their use has been preauthorized by Anthem CarelonRx.

To apply for preauthorization, your Doctor must contact Anthem CarelonRx at the number shown on page 91. Anthem CarelonRx will review your case with your Doctor and determine whether the Drug should be preauthorized. The Drugs requiring preauthorization may change from time to time. To find out if a prescription drug is covered, contact Anthem CarelonRx.

Call the TBT Plan Administration Office with questions about your prescription drug benefits. Also see *What is Not Covered Under the Outpatient Prescription Drug Benefit* on pages 40-41.

## Temporary Waiting Period for New Pharmaceuticals

New medications are excluded from coverage when first available to the public to allow time for review of their safety and effectiveness during the first six months when the Drug is available by prescription. If your Doctor prescribes a Drug that has been temporarily excluded as a "New Drug to Market," you should discuss alternatives with your Doctor.

For participants who attempt to fill a medication that has been temporarily excluded under the program at a retail pharmacy, Anthem CarelonRx will notify the pharmacy at point of sale when a medication is temporarily excluded by the Plan. You, your Doctor or Pharmacist may also call Anthem CarelonRx at the number listed on page 91 to discuss alternative medications.

## How to Use the Prescription Drug Program

When the TBT Plan Administration Office receives your *TBT Enrollment Form* (and medical/dental option forms), their customer service representative will ask Anthem CarelonRx to send your welcome package that contains your prescription drug ID card. You must present this ID card at a participating pharmacy when you need to fill a prescription. The pharmacy will use the information printed on your ID card to check your eligibility and coverage status, and will bill the Plan electronically, fill your prescription and collect the Copayment (if any).

Some participating pharmacies are unable to transmit billing online for compound medications or other covered prescription Drugs. If this happens for a covered medication, you will need to pay cash to receive your medications and later submit your receipt for reimbursement by Anthem CarelonRx using the *Direct Member Reimbursement Claim Form*. See *Using Non-Participating Pharmacies* on page 40 for details about how to use this reimbursement form (even though that prescription may be filled by a participating pharmacy).

If you need help locating a participating pharmacy, call Anthem CarelonRx at the number listed on page 91.

## Using Non-Participating Pharmacies

If for any reason you use a pharmacy that is not in the Anthem CarelonRx Network, you must pay the full cost of the prescription up-front and are reimbursed once you send Anthem CarelonRx a completed *Direct Member Reimbursement Claim Form*. **Specialty Drugs and injectable medicines that require preauthorization are *not available* through retail pharmacies.**

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

Fill out your portion of the *Direct Member Reimbursement Form*. Your Pharmacist must fill out the bottom section. Send the completed form to Anthem CarelonRx at the address printed on the form. This same process applies if you have not yet received your ID card and need a prescription to be filled.

### MEDICARE-ELIGIBLE ACTIVE EMPLOYEES

***If you are Medicare-eligible, but currently covered under a TBT Plan for active Employees*** *(either under the Indemnity Plan, Kaiser or the Anthem Blue Cross HMO),* ***do not enroll in a Medicare Part D program****. Your current TBT prescription drug coverage (or your coverage under an HMO through TBT) is at least as good, on average, as Medicare Part D.* ***If you enroll in a Medicare Part D program, you will lose your TBT prescription drug coverage altogether.***

## What is Not Covered Under the Outpatient Prescription Drug Benefit

The Plan covers only Medically Necessary medications prescribed by your Doctor. The following Drugs or medicines are not covered if they are:

1. Administered or billed by a Hospital or Skilled Nursing Facility related to inpatient treatment or services, or not dispensed by a licensed Pharmacist.
2. Received without charge through local, state or federal programs, including Workers' Compensation.
3. Prescribed for Accidental Injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service connected.
4. Legally available without a prescription—except insulin and insulin syringes (when prescribed by a Physician)—and Drugs required to be covered in compliance with the Affordable Care Act including, but not limited to, aspirin, folic acid supplementation, fluoride supplementation, iron supplements and Vitamin D.
5. Replacing lost or stolen medication unless preauthorized. Contact the Anthem CarelonRx customer service department for preauthorization.
6. Available to you at no cost ("no cost" not "no Copayment").
7. Cosmetics, health and beauty aids, or drugs prescribed for Cosmetic purposes and not Medically Necessary (such as Retin-A).
8. Charges higher than 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 even when prescribed (unless Medical Necessity is clearly established, as in prenatal vitamins during pregnancy or if covered as a Preventive Care service required by the Affordable Care Act).
11. Anabolic steroids.
12. Growth hormones (unless preauthorized by Anthem CarelonRx or Anthem Blue Cross).
13. Fertility Drugs (unless used to *maintain* a pregnancy).
14. Allergy serums.
15. Viagra and any other Drugs for the treatment of impotence, unless Medical Necessity is clearly established as determined by Anthem Blue Cross.
16. For hair restoration, including but not limited to Rogaine and Minoxidil.
17. Genetically engineered and/or immune altering Drugs (even when injectable) unless preauthorized by Anthem Blue Cross or Anthem CarelonRx.
18. Immunization agents, biological sera or plasma.
19. Diet medications, appetite suppressants, dietary or nutritional supplements and liquid diet food, or any food that may be purchased with or without a prescription.
20. Therapeutic equipment, devices or appliances, whether or not prescribed by a Doctor—including support garments and other non-medical items. In some cases, these items may be covered under the TBT Indemnity Medical Plan (see *Other Covered Expenses*, item 7 on page 29).

21. Charges for an unreasonable supply of Drugs (or more than the maximum 100-day supply).
22. Refills not authorized by the prescribing Physician.
23. Refills requested sooner than appropriate after last filled (except in cases of an emergency).
24. Dispensed a year or more after the prescription date.
25. Prescription Drug Claims not filed within one year of purchase.
26. Prescriptions filled prior to enrollment in coverage or after termination of coverage.
27. Prescribed for conditions or treatments not covered by the Plan.
28. Investigational or Experimental (unless taken as part of an approved clinical trial explained in item 10 on page 34. See the definition of *Experimental Treatment* on page 83 for more information).
29. Charges to administer prescription Drugs or insulin injections.
30. Not fully approved by the U.S. Food and Drug Administration (FDA) (unless taken as part of an approved clinical trial explained in item 10 on page 34).
31. Specialty pharmaceuticals or injectable medications that were not preauthorized by Anthem CarelonRx using the required procedures explained on pages 37-39.
32. Specialty and high-cost Drugs for which coverage is determined under the Medical Plan (see *What is a Specialty Drug?* on page 38).

## Claim Filing Procedures

See *Claiming Benefits* (beginning on page 55) 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 when you first enrolled or during Open Enrollment. The current options include Delta Dental, Bright Now! Dental, or United Healthcare Dental (UHC Dental)—but these options are subject to change.

See the *Comparison of Dental Benefits* to review the current options. Also see your Plan's *Summary of Coverage* for details about your dental benefits.

The *Comparison of Dental Benefits* is intended as a summary and does not fully describe your benefit coverage. For details about the Bright Now! and UHC Dental options, see each organization's *Evidence of Coverage*. To obtain copies of an *Evidence of Coverage*, call the TBT Plan Administration Office.

## DENTAL OPTIONS

During your first 12 months of TBT coverage, your dental options are Option 2 (Bright Now! Dental) and Option 3 (United Healthcare Dental). After you complete 12 months of coverage in your TBT Plan, you can choose Option 1 (the Indemnity Dental Option).

*Indemnity Dental (Option 1)* is the TBT dental option administered by Delta Dental. You may see the licensed Dentist of your choice, but your out-of-pocket expenses are usually lower if you choose a Delta Dental Dentist. Option 1 is not available until you complete 12 months of coverage in your TBT Plan, unless you meet one of the following exceptions:

1. You live more than 30 miles from the nearest Bright Now! Dental or UHC Dental office that is accepting new patients.
2. All covered persons in your household do not live in the same household and one or more covered family members lives more than 30 miles from the nearest Bright Now! Dental or UHC Dental office that is accepting new patients.
3. You received treatment from a Delta Dental Dentist within the past 12 months (and can, upon request, provide an invoice to verify such treatment) and wish to continue receiving treatment from that Dentist while enrolled in your TBT Plan.
4. You were previously covered under TBT Dental Option 1 within the past 12 months.
5. You are exempted from the TBT new Employee waiting period requirements, or
6. You are part of a new Employer Group which just began participation in a TBT Plan.

*This Guide describes Option 1—Indemnity Dental benefits.*

***Prepaid Dental Plans Bright Now! Dental/Newport (Option 2)*** and ***United Healthcare Dental (Option 3)*** are the other dental options offered through TBT (at the time this *Guide* is printed). Both Option 2 and Option 3 are prepaid dental programs providing Covered Services through designated dental offices throughout California.

"Prepaid" means that TBT pays a set fee on your behalf each month and the dental plan provides you with dental treatment.

If you are enrolled in Option 2 or Option 3, **you must go to a Dentist in their Provider Networks or you won't have coverage**. To find Dentists for Option 2, go to www.brightnow.com. To find Dentists for Option 3, go to www.uhc.com/find-a-doctor. Or contact your prepaid dental option at the phone numbers listed on page 91.

## 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 *When Your Coverage Begins* starting on page 4).

In addition: **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.**

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

## INDEMNITY DENTAL (OPTION 1) BENEFITS

### Limitations for Initial Coverage

Under your TBT Plan, dental option benefits may be limited during the first six months of coverage to exams, cleanings, x-rays and simple fillings. Some Plans have Deductibles, but none apply to Preventive Care. Some plans have annual maximums for dental care. See your *Summary of Coverage* and *Comparison of Dental Benefits* for more details.

### 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*. However, your TBT Plan may require that dental Deductibles are met before paying other types of expenses under the Indemnity Dental Option.

Check your Plan's *Summary of Coverage* and *Comparison of Dental Benefits* for details about Deductibles, Coinsurance percentages and any Copayments and maximum amounts that may apply to your dental benefits.

After you satisfy the Deductible amounts listed in your *Summary of Coverage*, the Indemnity Dental Option pays Covered Expenses at your TBT Plan's dental Copayment percentage for the rest of the calendar year.

### DEFINITIONS

*Certain words used in this section of the **Guide** have meanings specific to the Indemnity Dental Option:*

***Covered Expenses.** 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 higher than UCR in your geographical area are not covered by the Plan and are payable by you.*

***Covered Services.** The dental services covered according to TBT's 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 Indemnity Dental Benefits.*

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

***Usual, Customary and Reasonable (UCR).** For non-Delta Dentists, Delta Dental sets a "program allowance" for each dental procedure. The Program allowance is based on what Dentists charge for a given procedure in your geographic area and is intended to reflect the reasonable cost of the dental procedure.*

### 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 PPO Network.

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

To find a Delta Dental Dentist, call (800) 765-6003. You can also visit their website at www.deltadentalins.com or call their Provider Finder Service at (800) 427-3237.

### Covered Expenses—Indemnity Dental Option

The Indemnity Dental Option covers the services listed in this section. (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* under *What is Not Covered* on pages 44-46. 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*

Preventive Care includes:

- Two examinations, consultations and/or office visits per calendar year that include cleaning, scaling, polishing and fluoride treatments. **Note:** Pregnant women are entitled to an additional oral exam and either a routine oral cleaning or periodontal scaling with root planing per calendar year.
- Full mouth x-rays once every five years.

- Panoramic x-ray once every five years.
- Bitewing x-rays, twice in a calendar year, for covered Children up to age 18 and once in a calendar year for covered adults (including Dependents over age 18).

### 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 (except for pregnancy, as noted on the previous page).

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 of treatment.
7. Sealants for Children through age 15.

***Coinsurance percentages, Deductibles, benefit maximums and other limits vary by TBT Plan.*** *Also check your* ***Summary of Coverage*** *and* ***Comparison of Dental Benefits*** *for details that may apply to your dental coverage.*

### Major Care

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

Major care includes:

1. Crowns, inlays, onlays and cast restorations (caps, inlays and onlays) only if they are needed to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations.
2. Prosthodontic devices, including implants to save a tooth and the construction or repair of fixed bridges, partial dentures and complete dentures, if provided to replace missing natural teeth.

   Because dental implants are now recognized as an alternative to conventional tooth replacement (such as bridges and dentures), implants are covered subject to your Plan's new Employee restrictions, limitations and maximums for major care (see your *Summary of Coverage* and *Comparison of Dental Benefits*). **Note:** Major care also includes coverage for cone beam x-rays that are Medically Necessary, implant repair, recementation or removal and implant-supported prosthetics.
3. Certain non-surgical procedures to treat temporomandibular joint dysfunction (TMJ) as explained in your *Summary of Coverage* and *Comparison of Dental Benefits*.

### Orthodontia

If your TBT Plan covers Orthodontia, treatment involves dental appliances, such as braces, to straighten or realign teeth or jaws that do not function properly. For eligible participants and covered Dependents, there are Copayments and lifetime maximums for orthodontic benefits. However, orthodontic benefits may not be available under your TBT Plan (see your Plan's *Comparison of Dental Benefits* and *Summary of Coverage* for details).

**Note:** If your Plan provides orthodontic benefits for Dependent Children, they are only eligible up to their 26th birthdays. Since orthodontic treatments may take 24 months or longer, this care should start before his or her 24th birthday. **In the month when he or she reaches age 26, the Dependent Child's orthodontic coverage will end.** You would be responsible to pay for further orthodontia treatment (unless the Dependent is eligible for and enrolls in COBRA coverage).

### Dentures

For a standard, partial or complete denture, the Plan pays its Copayment percentage (as explained in your *Summary of Coverage*) of the Dentist's fees up to a maximum fee allowance. The fee allowance is the average amount charged by most Delta-participating Dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods.

## 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. Benefits are NOT payable for:**

1. More than two oral examinations per calendar year, including office visits for examinations and Specialist consultations (or a combination).
2. More than two adult Prophylaxis (except during pregnancy), fluoride treatments (for a covered child) or procedures that include cleanings in a calendar year.

3. More than one set of full mouth x-rays in any five consecutive years. Bitewing x-rays on request by the Dentist, but not more than twice in any calendar year for Children to age 18, or once in any calendar year for adults ages 18 and over.
4. Sealants other than to permanent first molars through age eight and second molars through age 15 provided they 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 its application.
5. Crowns, jackets or cast restorations on the same tooth more than once every five years.
6. Prosthodontic devices (such as implants) more than 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.
7. Treatment of temporomandibular joint dysfunction (TMJ) must be authorized in advance and is limited to your Plan's lifetime maximum after any Coinsurance percentages are met. Covered Expenses are paid at your Plan's Copayment percentage of Delta Dental rates (or UCR charges if a non-Delta Dentist). Covered Expenses are payable at your Plan's Copayment percentage for temporary repositioning appliance, occlusal guard, occlusal adjustment (complete) or removable metal overlay stabilizing appliance. Benefits must be preauthorized based upon the treating Dentist's documentation of the treatment plan and the need for the proposed treatment as determined by the Plan.

### *Exclusions*

**Benefits are NOT payable for the following:**

1. Treatment before the patient was eligible for Plan benefits.
2. *For Delta Dentists:* Claims are paid based on PPO-contracted fees for PPO Dentists. PPO Dentists' charges in excess of contracted fees are NOT payable by the Plan.
3. *For Dentists who are not Delta Dentists:* Charges higher than Delta's Program Allowance determines to be Usual, Customary and Reasonable (UCR).
4. 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.
5. 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.
6. Treatment for Cosmetic purposes (unless the expense is necessary to repair damage from an Accident, but only if such dental treatment takes place no later than two years from the date of the Accident and while still eligible).
7. Surgical treatment of temporomandibular joint dysfunction (TMJ) or orthognathic surgery: these expenses may be covered under your medical benefit. The Dental Plan covers removable appliances to reposition the lower jaw, removable appliances to stabilize the lower jaw, occlusal guards and occlusal adjustment-complete for treatment of TMJ.
8. 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 if the prosthesis is damaged beyond repair as a result of injury while in the mouth.
9. Expenses for facings on crowns or pontics posterior to the second bicuspid.
10. Temporary or permanent replacement of an existing prosthodontic device that could be made satisfactory.
11. If orthodontic treatment begins before the covered person becomes eligible for coverage, benefit payments start with the first payment due following enrollment. Plan payments stop with the first payment due immediately after loss of eligibility or if the patient terminates treatment for any reason before it is completed. **Note:** Some TBT plans exclude Orthodontia entirely. See your *Summary of Coverage* to confirm whether Orthodontia is covered by your Plan.
12. 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 under *What is Covered?* under Indemnity Medical Plan Option beginning on page 22).

13. 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.
14. 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.
15. Prescribed Drugs (see *Your Prescription Drug Benefits* beginning on page 36).
16. Hospital costs and any other fees charged by a Dentist for Hospital treatment.
17. Experimental procedures.
18. Anesthesia, except for general anesthesia or I.V. sedation given by a licensed Dentist for oral surgery services and select endodontic and periodontic procedures. Medically Necessary anesthesia for pediatric dentistry is covered under the Medical benefit.
19. Grafting tissues from outside the mouth to tissue inside the mouth (extraoral grafts).
20. Fees for specialized techniques involving precision dentures, personalizing or characterization.
21. Dietary planning.
22. Training in oral hygiene or Preventive Dental Care.
23. Treatment for services or oral surgeries that are covered under your TBT medical option.
24. Hypnosis.
25. Charges for failure to keep scheduled appointments.
26. Expenses for which there is no legal obligation to pay.
27. 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.
28. Replacement of a crown, bridge or dentures that are lost or stolen.
29. Treatment other than full dentures that are needed solely to change the vertical dimension of teeth.
30. 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 or orthodontic work that could involve **$500** of Covered Expenses or more, your Delta Dentist should send a *Pre-treatment Estimate Form* to Delta Dental before treatment begins.

You can request an estimate even if the cost of treatment is expected to be less than **$500**. Then you will know how much the Indemnity Dental Option pays—and how much you will be expected to pay—before treatment begins. In a few days, Delta Dental returns the estimate to your Dentist.

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 36.)

### Coordination of Dental Benefits

Coordination of Benefits rules apply whenever you or a covered Dependent has coverage under a TBT dental option and another dental plan. Coordination of Benefits rules are explained starting on page 66. Benefits from the Indemnity Dental Option may be reduced by the amount of any benefits for the same expenses provided by another health plan or government program 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 and are yet to be completed.

Extended benefits are usually covered as long as the services are received within 30 days after dental coverage ends. Preventive Care (such as teeth cleaning or x-rays) is not considered "treatment," and 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.
4. An ongoing orthodontic treatment plan up to 30 days (if covered under your TBT Plan as explained in your *Summary of Coverage*).

Consultation for a procedure without any preparatory work yet performed is *not* "a dental procedure that began while you were still eligible for benefits."

### *Continuing Coverage When Dental Coverage Ends*

(See *When Coverage Ends* on page 9.)

You may be able to continue dental coverage through COBRA (see the section starting on page 14 for more information on COBRA coverage). But to continue dental coverage you must also elect to continue medical coverage.

### *Claim Filing Procedures*

See *Claiming Benefits* (beginning on page 55) for details about Claim filing and appeals procedures.

## PREPAID DENTAL (OPTIONS 2 AND 3)

TBT 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 2)
- United Healthcare Dental (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 Dentists. You will be asked to choose a dental office from among those offered by the Prepaid Dental option in which you enroll.

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 option.

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, you will not 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 *Evidence of Coverage* or specific brochures about Covered Services, patient charges, participating Dentists and special limitations under your dental option before receiving care.

### *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 dental option and may change from time to time. There may also be changes in available Dentists or staff.

Check each dental option's separate brochures and *Evidence of Coverage* 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 each dental option's claim filing and appeal procedures.

#### *REMINDER*

*Before having any work performed, it is a good idea to ask the Dentist if you are responsible for any charges.*

#### *OPEN ENROLLMENT*

*After your initial dental option election, you may make changes to your dental option once every 12 months. Each time you change a medical or dental option, a new 12-month Open Enrollment period begins. See pages 10-11 for Open Enrollment details.*

*You and your eligible Dependents must be covered under the same medical and dental options.* ***Note:*** *You will not be sent medical or dental option change forms unless you request them.*

*Check the* ***Comparison of Dental Benefits*** *and* ***Dental Option Form*** *for details about your Plan's dental options. The prepaid dental options have special materials and provider lists (available by calling the prepaid dental options' phone numbers listed on page 91).*

#### *DISENROLLMENT*

*The Plan will allow you and your Dependents to disenroll from your dental coverage.* ***Note:*** *Disenrolling from dental coverage will rarely be in your best interest. Your Employer's monthly contribution for coverage (and, if applicable, your share of the contribution) will not be reduced if you opt out of dental coverage. After you disenroll, you will not be able to re-enroll in dental coverage for another 12 months. Call the TBT Plan Administration Office if you intend to disenroll from dental coverage.*

# Your Vision Care Benefits

Vision care benefits are provided through Vision Service Plan (VSP), which maintains a Network of licensed opticians, ophthalmologists and optometrists throughout the country.

You may choose any licensed eye care professional, but the benefits paid will be greater when you use a VSP Provider. You and your covered Dependents do not 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 *When Your Coverage Begins* starting on page 4).

You have the vision care benefits described here no matter which medical or dental options you choose. So even Kaiser and Anthem Blue Cross HMO enrollees have the vision coverage described in this *Guide*—unless a Kaiser member has separately enrolled in the Kaiser vision benefit program.

### *Treatment of a Condition or Injury Affecting Your Eyes*

If you need surgery or develop a medical condition affecting your eyes from an illness or a non-occupational injury, refer to *What is Covered* under the *Indemnity Medical Plan Option* section beginning on page 22. (HMO members may refer to their surgery coverage through the HMO.)

If an eye injury or illness results from work or working conditions, contact your Employer for information about Workers' Compensation benefits.

## WHAT VISION CARE IS COVERED

The vision care benefits described here 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 do not need to request a VSP form in advance to visit a VSP Provider. But it is critical that you mention your coverage is through VSP when you set up your appointment. The VSP Provider must contact a VSP representative in advance of your visit to confirm 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 TBT Plan's benefits. Also check your *Summary of Coverage* for details about your vision care coverage. You can log in at www.vsp.com to locate a VSP Provider.

*Step 2.* Contact a VSP Provider and make an appointment. Identify yourself as a VSP patient and provide your Social Security number. If you need help locating a VSP Provider, call VSP at (800) 877-7195 or go to www.vsp.com.

*Step 3.* The VSP Provider 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 will notify you.

*Step 4.* 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 49 and 50.

*Step 5.* You pay the VSP Provider directly for any non-covered expenses—see page 51 for what is not covered.

## 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 for your services, materials or supplies and send the itemized bill to Vision Service Plan at the address listed on page 91 (within six months of the date of service). Or you can submit your out-of-network Claim online at www.vsp.com. Be sure to 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 will reimburse you for covered services and materials—and only at the specific non-VSP rates listed in the charts on this page and on page 50—if you file within the six-month deadline. You are not reimbursed for treatment or supplies that are not covered benefits.

## Vision Care Services—Exams and Eyeglasses

Coverage varies by TBT Plan—check your *Summary of Coverage*.

| Exams and Eyeglasses (every 12 or 24 months depending on your Plan) | VSP Provider | Non-VSP Provider |
|---|---|---|
| **Routine Vision Exam** once every 12 or 24 months depending on your TBT Plan | Covered within allowance, Copayment may apply | $50 maximum benefit |
| **Single vision lenses (standard size)** one set every 12 or 24 months if prescribed | Basic lenses in glass or plastic without any enhancements are covered in full | $50 maximum benefit |
| **Bifocal lenses** one set every 12 or 24 months if prescribed | | $75 maximum benefit |
| **Trifocal lenses** one set every 12 or 24 months if prescribed | | $100 maximum benefit |
| **Lenticular lenses** one set every 12 or 24 months if prescribed | | $125 maximum benefit |
| **Lens Enhancements** Scratch coating, AR coating, removal of lines or progressive lens upgrade, high indexing or other enhancements | An average of 35-40% discount on many lens enhancements | No additional benefit |
| **Basic frames** new frames once every 12 or 24 months depending on your TBT Plan | Covered in full up to $150 and a 20% discount on cost of frames exceeding $150 | $70 maximum benefit |
| **Tint** | Pink #1 or #2 covered at no additional cost for some TBT Plans | $5 maximum benefit |

## Additional Frames and Lenses

VSP patients may buy additional pairs of prescription glasses at a 20% discount. If you used your vision benefits to purchases glasses, 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 Provider for details.

## How Often am I Eligible for New Lenses and Frames?

Eligibility for exam, lenses and contact lenses is limited to once every 12 months and once every 24 months for frames. These limits apply even if lenses or glasses are lost or stolen.

## If You Prefer Contact Lenses

You may want to receive benefits (shown to the right) 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, the 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 **$130** contact lens allowance is applied toward any contact lens fitting and/or evaluation and contact lens materials.

| Contact Lenses | VSP Provider | Non-VSP Provider |
|---|---|---|
| **Medically Necessary**<br>• Following cataract surgery<br>• To correct extreme visual problems that cannot be corrected with eyeglasses<br>• 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 ($125 per eye) includes cost of exam, contact lenses and any other material. |
| **Cosmetic**<br>Not Medically Necessary as defined on this page | The Plan provides a $130 allowance for contacts. The Copayment does not apply to the contact lenses. However, there is a $60 maximum Copayment for contact lens exam fitting and evaluation. | The Plan covers up to $105 for the eye examination and contact lens fitting evaluation and contact lens materials. |

* *Contact lenses are covered in lieu of the Plan's eyeglass benefit. In other words, you cannot collect the benefit for* ***both*** *contacts and glasses in the same 12- or 24-month period.*

### REMINDER

*If you select services, materials or supplies that cost more than the Plan allows, you pay the extra charges. However, as noted in the charts on page 49 and on this page, if you use a VSP Provider, a discount may apply to these extra charges.*

## Cosmetic Options

Your 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 the Cosmetic options below:**

1. Blended lenses.
2. Oversize lenses.
3. Contact lenses (except as noted on this page).
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 treatment above the 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 page 50, benefits are NOT payable for the vision services or supplies listed below:

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.
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 your Plan's *Summary of Coverage*.

### DISENROLLMENT

*The Plan will allow you and your Dependents to disenroll from your vision coverage.* ***Note:*** *Disenrolling from vision coverage will rarely be in your best interest. Your Employer's monthly contribution for coverage (and, if applicable, your share of the contribution) will not be reduced if you opt out of vision coverage. After you disenroll, you will not be able to re-enroll in vision coverage for 12 months. Call the TBT Plan Administration Office if you intend to disenroll from vision coverage.*

## Claim Filing Procedures

See *Claiming Benefits* (beginning on page 55) for details about Claim filing and appeals procedures.

# Life and Accidental Death and Dismemberment Benefits

The Teamsters Benefit Trust provides Employee life insurance protection and benefits payable in the event you are severely injured through an insurance policy issued by the Prudential Life Insurance of America (Prudential). The Insurance benefits applicable to your Plan are stated in your *Summary of Coverage*.

The insurance protections described in this *Guide* are subject to the terms of the insurance policies under which the benefits are provided. If there are any conflicts between the benefits described here and the policy (which is called the Group Insurance Certificate), the insurance policy will always govern.

***YOUR INSURANCE COVERAGE MAY DEPEND ON THE STATE WHERE YOU LIVE***

*There are state-specific requirements that may change your life or accidental injury coverage described in this section. If you live in a state that has such requirements, like California, those requirements will apply to your Coverage and are made a part of the Group Insurance Certificate. Prudential's website describes these state-specific requirements at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence, your email address and your Access Code. The Access Code for TBT participants or Dependents is **93876** (as of the date when this Guide is printed).*

*Note that the Prudential website references personal accident insurance and business travel accident coverage. However, your TBT Plan does not offer that coverage but provides Life and Accidental Death and Dismemberment Benefits. See your Plan **Summary of Coverage** for details regarding your coverage for Life and Accidental Death and Dismemberment Benefits.*

## When Coverage Begins

You and your covered Dependents become eligible for life insurance benefits at the same time that you are eligible for your other TBT benefits (see *When Your Coverage Begins* starting on page 4).

## What is Covered

Life insurance benefits are payable upon your death. The Accidental Death and Dismemberment (AD&D) Benefits are payable in the event of an Accident (see page 80 for definition of *Accident and Accidental Injury*) which directly causes 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.
7. Quadriplegia, paraplegia or hemiplegia.
8. Total and permanent loss of speech or hearing in both ears.
9. Loss of thumb and index finger of the same hand.

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

For information about losses related to Dependent life insurance benefits, see your *Summary of Coverage*.

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

While life insurance benefits are payable following the covered person's death by any cause, AD&D benefits are NOT payable for losses that are caused by:

1. Disease.
2. Illegal drug use, 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.
   - Your commission of a crime.
   - 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 *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 the TBT Plan Administration Office. Beneficiary designations made on forms used by pension or other health and welfare plans will not be accepted. Contact the TBT Plan Administration Office if you need a *TBT Enrollment Form*.

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.

A change in marital status (including divorce) does ***not*** automatically change your beneficiary designation.

**In the event of a divorce or other change in circumstances, 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.**

## Claim Filing Procedures

See *Claiming Benefits* (beginning on page 55) for details about Claim filing and appeals procedures.

### *Claim Filing Deadline*

Claims should be filed as soon as reasonably possible. The TBT Plan Administration Office can send you or your beneficiary the benefits application form and help with the Claim filing process.

Prudential must be provided with proof of loss within 90 days from the date of loss. If it is not reasonably possible to do so within 90 days, the Claim must be filed as soon as reasonably possible. **However, 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 or injury is caused by an Accident, a copy of the accident report must also be supplied with the application.

**Submit Life and Accidental Injury insurance Claims to the TBT Plan Administration Office**, Attn: Life and Accident Department at the TBT address listed on page 1.

## Extension of Coverage

If you are under age 60, and you become Totally Disabled while covered, your death benefit coverage may be extended for up to one year, even though you are not working. See page 82 for a definition of *Total Disability*). To qualify for this extension, the Disability must last for at least nine months.

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.

You must apply for the individual contract and pay the first premium according to the following rules: (1) If you have been given written notice of the conversion privilege by the 15th day after your TBT coverage ends, you must apply for the individual contract and pay the first premium by the 31st day after your TBT coverage ends, or (2) If you have been given written notice of the conversion privilege more than 15 days after your TBT coverage ends, you must apply for the individual contract and pay the first premium by the 25th day after you have been given the notice.

You cannot convert the TBT insurance benefit to an individual contract if you do not apply for the contract and pay the first premium prior to the 92nd day after your TBT Life Insurance benefit ends. Upon request, the TBT Plan Administration Office will send 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 most recent *TBT Enrollment Form* received by the TBT Plan Administration Office before your death.

## Dependent Life Insurance (Certain TBT Plans Only)

Certain TBT Plans provide Dependent Life Insurance benefits (as explained in your *Summary of Coverage*). If your TBT Plan provides Dependent Life Insurance benefits, enrollment is automatic. See your *Summary of Coverage* to determine whether your TBT Plan provides Dependent Life Insurance benefits.

### *Payment of Benefits*

You, the Plan participant, are automatically the beneficiary for a covered Dependent's Life Insurance Benefit. If you are not living, benefits will be paid as follows:

1. To your Spouse if living; otherwise,
2. To your Children (including your legally adopted Children); otherwise,
3. To your estate.

Two or more persons entitled to benefits will be paid in equal shares.

**To file a Claim for Dependent Life Insurance, contact the TBT Plan Administration Office.** The application must contain a certified copy of the death certificate with an embossed seal. If you and your Spouse are both covered Employees under a TBT Plan which provides Dependent Life Insurance benefits, your eligible Dependent Children may be covered under each parent's coverage.

### *Conversion Privileges for Dependents*

Dependents may convert their Life Insurance coverage to an individual policy within 31 days after their Employer-paid TBT coverage ends. Individual coverage may take effect as of the date your Dependent Life Insurance ends.

You must apply for the individual contract and pay the first premium according to the following rules: (1) If you have been given written notice of the conversion privilege by the 15th day after your TBT coverage ends, you must apply for the individual contract and pay the first premium by the 31st day after your TBT coverage ends, or (2) If you have been given written notice of the conversion privilege more than 15 days after your TBT coverage ends, you must apply for the individual contract and pay the first premium by the 25th day after you have been given the notice.

You cannot convert the TBT insurance benefit to an individual contract if you do not apply for the contract and pay the first premium prior to the 92nd day after your TBT Life insurance benefit ends. Upon request, the TBT Plan Administration Office will send you the forms you need to apply for a Conversion Policy.

No medical exam is needed to convert Dependent Life coverage to an individual policy if you apply for and pay the required premium within the 31-day conversion period. The Conversion Policy will not be the same as group coverage through TBT. The premium is based on age, risk factors and the insurance company's rates.

If your covered Dependent dies during the conversion period, Plan benefits will be payable to you, or if you are not living, in the order described on this page.

### *When Dependent Coverage Ends*

Coverage for your Dependents ends when your coverage ends or when your Dependents are no longer eligible, whichever comes first. (See the definitions of *Dependent* on pages 4, 6 and 82 for more information about Dependent eligibility.)

## Claim Filing Procedures

See *Claiming Benefits* (beginning on page 55) for details about Claim filing and appeals procedures.

# Claiming Benefits

When you have a Covered Expense, it is often unnecessary to file a Claim. In many cases, the Provider handles all the claim filing. This section explains what to do if claim filing is needed.

## CLAIM FILING

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

- *In-network Medical Benefits*. When you use a PPO Hospital, Doctor or other Provider.
- *HMO Benefits*. When you use HMO facilities in your usual service area (see the HMO's *Evidence of Coverage* for more information).
- *Indemnity Dental Benefits*. When you use Delta Dental Providers.
- *Prepaid Dental Benefits*. When you use the prepaid Providers and facilities.
- *Prescription Drug Benefits*. When you use Anthem CarelonRx participating pharmacies or the mail order service. **Note:** Some TBT Plans require that Kaiser enrollees use a Kaiser pharmacy only. See page 10 and your *Summary of Coverage* for details.
- *Vision Care Benefits*. When you use VSP Providers.

If you use a PPO Provider, that Provider will file a Claim on your behalf. If you use a Non-PPO Provider, that Provider may file a Claim with Anthem Blue Cross.

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

- *Vision care benefits when you do not use VSP Providers*. Send itemized bills for covered services to VSP as described on page 49.
- *Life Insurance and Accidental Death & Dismemberment benefits* and Dependent Life Insurance benefits if applicable.

## 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 or by downloading it from the TBT website at www.tbtfund.org.
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 90 days of the date when the Claim was incurred. **In no event, except the loss of legal capacity, will a Claim be processed later than 12 months after the Claim was incurred.**

   **If you do not provide all the required information and itemized receipts, processing of your Claim will be delayed or even denied.**

### *Late Claims*

If a Claim is not submitted within 12 months from the date of service, it will not be paid.

### *What is a Claim and What Does It Require?*

A Claim is any request for Plan benefits made under the Plan's Claim filing procedures. Inquiries about Plan provisions unrelated to a specific claim for benefit coverage or concerning whether you are eligible for coverage under a TBT Plan are *not* "Claims" covered by these procedures. However, if you file a Claim for benefits that is denied because you were ineligible for Plan coverage at the time, that denial is a "Claim" for purposes of the procedures described in this *Guide*. A benefits Claim requires that you include all of the following information on your (or your medical Provider's) claim form:

- Your name.
- The patient's name.
- Patient's birth date.
- Patient's Social Security number.
- The date of service.
- The diagnosis and applicable ICD 10, CPT and HCPCS codes for any treatment (the codes 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 health 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 Anthem Blue Cross approves a course of 10 treatments over three months, and after seven treatments, Anthem Blue Cross 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 57.*

***Post-Service Claim:*** *Any Claim other than a Pre-Service or Disability Claim.*

## Filing Different Types of Claims

### *Filing Pre-Service Claims (Non-Urgent Care)*

Benefits are NOT payable unless you have received approval ***before*** treatment for the following types of admissions and Claims:

- *Hospital admission for non-urgent care.* Anthem Blue Cross must approve any Hospital admission—except Emergency care admission—before you are admitted to the Hospital.
- *Treatment for non-urgent alcohol or chemical dependency.* The Teamsters Assistance Program of Northern California (TAP) or the Teamsters Alcohol/Drug Rehabilitation Program (TARP) must preauthorize any non-urgent Hospital admission. TAP can be reached at (510) 562-3600 or (800) 253-TEAM. If you are represented by Teamsters Locals 87, 137, 150, 386, 431, 439, 533 or 948, the Teamsters Alcohol/Drug Rehabilitation Program (TARP), rather than TAP, oversees Hospitalization due to alcohol or chemical dependency treatment. Call TARP at (800) 522-8277 or (209) 572-6966.
- *Home Care or any kind of alternative to inpatient care.*
- *Skilled Nursing Facilities or Hospice Services.* For Pre-admission Certification of Hospital admissions, Home Health Care, alternative care or Hospice Services, you (or your Doctor) must call Anthem Blue Cross at (800) 274-7767.

You will receive a response to Pre-Service Claims **within 15 days** of TBT's receipt of the Claim. In cases where more time is required, the Plan has 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 Urgent Care Claims*

- *Hospital Admission for Urgent Care.* In an emergency, Anthem Blue Cross must be notified as soon as possible following admission (and no later than 72 hours after admission). The Hospital or Physician must call Anthem Blue Cross at (800) 274-7767. 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, Anthem Blue Cross 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 by the Plan 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.

***Is "Urgent Care" the same as an "Emergency"?*** *For purposes of Claim filing, yes. In an Urgent Care Claim, you are already being treated while the Claims notice and response process has begun.*

- *Hospital Admission for Urgent Care Related to Alcohol or Chemical Dependency Treatment*. You must contact TAP or TARP as soon as possible following admission for alcohol or chemical dependency (and no later than 72 hours after admission).

  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, TAP or TARP 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. See *Claiming Benefits* beginning on page 55 for more information.

  **Note: Hospital admission for urgent care related to Alcohol or Chemical Dependency Treatment—in addition to any other related medical diagnoses—must be reviewed by Anthem Blue Cross, as described in this *Guide*.**

### *Filing Concurrent Care Claims*

A Concurrent Care Claim is where the Trust has approved an ongoing course of treatment to be provided over a period of time or number of treatments and sometime after that approval, but before the course of treatment has been completed, the Trust reduces or terminates the course of treatment altogether. 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 (where it is then referred to the appropriate Review Organization).

For medical Claims, the Claim is referred to Anthem Blue Cross; for alcohol or chemical dependency treatment, to TAP or TARP; for prescription drug Claims, to Anthem CarelonRx; 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*

Post-Service Claims are Claims where payment is being requested for medical care already rendered to the claimant. If your Post-Service Claim is complete, you will be 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. If you timely provide the requested information, the Plan will make a decision on your Claim within 15 days.

## How to File a Claim for Prescription Drug Benefits

If you get your prescription through an Anthem CarelonRx Network pharmacy or mail service, you do not need to file a Claim. If you purchase a covered prescription drug at a non-network pharmacy, you will need to pay **100%** of the cost to the pharmacy and file a *Direct Member Reimbursement Form* with Anthem CarelonRx. They will reimburse you for the amount that you would have paid at an in-network pharmacy minus any applicable Copayment.

### How to File a Claim for Vision Benefits

If you use a VSP Provider, you do not need to file a claim form. You will pay the amount due at the end of your visit and your Provider will take care of billing VSP for the remainder.

If you use a non-VSP eye care professional, follow the instructions for filing a Claim under *If You Choose Not to Use VSP Providers* on page 49.

If you have any questions about submitting your Claim, contact VSP directly.

### How to File an Indemnity Dental Claim

No claim forms are needed when you use Delta Dental Providers. Your Dentist bills Delta Dental directly.

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 File a Claim for HMOs and Prepaid Dental Options

If you are enrolled in a medical HMO or prepaid dental option offered through TBT, these organizations have *their own procedures for claim filing*. Contact the HMO or prepaid dental Provider directly.

### How to File a Claim for Disability Benefits

See pages 62-65—*Filing for and Appeal of Disability Claims*.

### Claim Payment Process for HMOs and Prepaid Dental Options

If you are enrolled in an HMO or prepaid dental option offered through TBT, these organizations have *their own procedures for claim payment and appeals concerning benefits*. Appeals concerning eligibility for benefits must always be sent to the TBT Plan Administration Office.

## APPEAL OF AN ADVERSE DECISION ON YOUR CLAIM

If your Claim is denied in whole or in part, for most types of Claims there is a two-level process to appeal. What "level" of appeal (who you direct your appeal to) depends on what type of Claim you are appealing—whether it is "urgent," "pre-service," "concurrent," or "post-service." All these terms are explained in the blue box on page 56. When a type of Claim has a "level one" and "level two" appeal, you must submit your appeal to level one *before* you can proceed to level two. See the charts on page 59 for details about each level of appeal.

### Appealing a Denied Claim for Indemnity Medical Benefits

If the Plan denies, reduces, terminates or fails to provide or make payment (in whole or in part) on a Claim for benefits, 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 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 is 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 of the Claim.
- 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 upon to decide your Claim.
- For Adverse Decisions based on the absence of Medical Necessity or the use of Experimental or investigational treatment (or for 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.

If you disagree with the decision on your Claim, you (or your Authorized Representative) may file a written appeal as long as you do so **within 180 days** after your receipt of the *Notice of Adverse Decision*. 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 do not appeal on time, you may lose your right to file suit regarding the Claim in court because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in court). See *Right to Sue* on page 62 regarding the 12-month deadline to sue the Trust after receiving notice of denial of an Adverse Decision on Appeal.

If your appeal concerns a Claim for urgent care, you or a Provider with knowledge of your medical condition (even if not your Authorized Representative) can appeal in writing or by phone by calling the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119. However, appeals of any Claims other than urgent care must be in writing.

The Plan will not defer to the initial adverse benefit determination and will consider all comments, documents, 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 based on the record, including any additional documents and comments you send.

If your Claim was fully or partially denied based on a medical judgment (such as not Medically Necessary or because it involved the use of an "investigational" or Experimental Treatment), the Board of Trustees will consult a health care professional (1) with training and experience applicable to the relevant field of medicine, (2) who will not have consulted during the initial denial, and (3) who is not a subordinate of the person who made the initial denial. 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 upon this advice in making its decision).

## Who Decides Your Appeal?

| Type of Claim | Level of Appeal | Who Decides the Appeal? | Deadline to File |
|---|---|---|---|
| **Urgent, Pre-Service or Concurrent Claims** | | | |
| Indemnity Medical Benefit Claims | Level One | Anthem Blue Cross | 180 days |
| | Level Two | TBT Board of Trustees | 15 days |
| Outpatient Drug Claims | Level One | Anthem CarelonRx | 15 days |
| | Level Two | TBT Board of Trustees | 15 days |
| Alcohol or Chemical Dependency Treatment Claims | Level One Only | TBT Board of Trustees | 15 days |
| Indemnity Dental | Level One | Delta Dental | 15 days |
| | Level Two | TBT Board of Trustees | 15 days |
| Prepaid Dental Claims—Bright Now! Dental | Level One Only | BrightNow! Dental | 15 days |
| Prepaid Dental Claims—United Healthcare Dental | Level One Only | United Healthcare Dental | 15 days |
| **Post-Service Claims** | | | |
| Indemnity Medical Benefit Claims | Level One | Anthem Blue Cross | 180 days |
| | Level Two | TBT Board of Trustees | 180 days |
| Indemnity Dental Claims | Level One | Delta Dental | 180 days |
| | Level Two | TBT Board of Trustees | 180 days |
| Prepaid Dental Claims—Bright Now! Dental | Level One Only | Bright Now! Dental | 180 days |
| Prepaid Dental Claims—United Healthcare Dental | Level One Only | United Healthcare Dental | 180 days |
| Outpatient Drug Claims | Level One | Anthem CarelonRx | 180 days |
| | Level Two | TBT Board of Trustees | 180 days |
| Alcohol or Chemical Dependency Treatment Claims | Level One Only | TBT Board of Trustees | 180 days |
| Vision Benefit Claims | Level One | VSP | 180 days |
| | Level Two | TBT Board of Trustees | 180 days |
| Life and AD&D Insurance Claims | Level One Only | Prudential | 180 days |
| **Eligibility Claims** | | | |
| Eligibility Issues and Exclusions from Plan | Level One Only | TBT Board of Trustees | 180 days |

## Post-Service Appeal Timeframes for Appeals

| Submission | Determination | Extension |
|---|---|---|
| Level One Appeal filed to Appropriate Claims Administrator that is not the Board of Trustees | Determination will be made on the appeal no later than:<br>• 60 days if one level of appeal,<br>• 30 days if two levels of appeal. | There is no extension permitted in the Level One appeal review. |
| Level One or Two Appeal filed to Board of Trustees **within 30 days** of the next Board meeting | Board review occurs no later than the second meeting following receipt of the appeal. | If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal. |
| Level One or Two Appeal filed to Board of Trustees **more than 30 days** before next Board meeting | Board review occurs at the next Board meeting date. | If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal. |

## Appealing a Denied Claim for Prescription Drug Benefits

### *What if I don't agree with an Anthem CarelonRx's decision about whether to cover my prescription?*

You can appeal any decision that denies payment for an item or service (in whole or in part) to Anthem CarelonRx. Submit written comments, documents or other information relevant to the appeal.

### *Who may file an appeal?*

You, your prescriber or your Authorized Representative may file an appeal of an Anthem CarelonRx denial of your prescription drug Claim.

### *How do I file an appeal?*

You must appeal a decision concerning a drug Claim within 180 calendar days from the date of this denial notification. You or your prescriber can get appeals information, including independent appeal rights, by contacting Anthem CarelonRx directly at the number listed on page 91.

### *How long does the appeals process take?*

If you proceed with the appeals process, Anthem CarelonRx will review the denial decision and provide you with a written determination **within 30 calendar days** of receiving your appeal.

### *What if my appeal is urgent?*

Generally, an urgent situation is one in which the standard time frame for a decision:

- Could seriously jeopardize your life or health or your ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

If you believe your situation is urgent, you or the prescribing Physician may request an expedited appeal by calling Anthem CarelonRx at the number listed on page 91 or in your *Summary of Coverage*.

You will be notified of the result of your expedited appeal **within 72 hours** from the receipt of the appeal request.

If you want to appeal an Anthem CarelonRx decision concerning your appeal to the Board of Trustees, you can then follow the appeals procedures for *Appealing a Denied Claim for Indemnity Medical Benefits* described on pages 58-59.

## How to Appeal a Denied Delta Dental Claim

In some cases, you may not agree with the decision made regarding a dental 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 Delta Dental *Explanation of Benefits*.

Remember to include your TBT Plan name (printed on the cover of your *Summary of Coverage*), your Social Security number and your phone number in your appeal. You should also include a copy of the treatment form or denial notice. Clearly explain what you are appealing and 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 phone number for complaints at (800) 400-0815. However, if you have a grievance against Delta Dental, you should first call Delta Dental at (888) 335-8227 and use their grievance process before contacting the State 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. **You may not appeal to the Board of Trustees until you have already exhausted Delta Dental's appeal process.**

## How to Appeal a Claim Denied by an HMO or one of the Prepaid Dental Options

If you are enrolled in an HMO or prepaid dental option offered through TBT, *these organizations have their own procedures for appeals concerning benefits*. However, appeals concerning eligibility for benefits must always be sent to the TBT Plan Administration Office.

## ADVERSE DECISION ON APPEAL

If you appeal an Adverse Decision, you will receive a *Notice of Adverse Decision on Appeal* that will contain all the information listed on page 58 concerning your appeal (except the appeal procedures and time limits).

You will receive notice of the decision on your Urgent Care Claim appeal within 72 hours of submission and within 30 days for other Pre-Service Claims.

Appeals of Post-Service and Disability Claims will generally be reviewed 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.)

Prior to the appeal decision, you will be provided free of charge with the following, *upon request* (and if applicable to your appeal):

- Any new or additional evidence relied upon or generated by the Plan in connection with the Claim or appeal.
- Any new or additional rationale supporting an adverse benefit determination.

You will be given a reasonable opportunity to review your Claim file and respond to the new evidence prior to a final decision being made by the Board. If the new evidence is received by you too late to have a reasonable opportunity to respond, the time frames explained on this page will be postponed until such time as you have had a reasonable opportunity to respond.

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.

## 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.

In the case of an urgent care appeal, only a health care Provider with knowledge of your medical condition can appeal on your behalf (even if you have not officially designated the health care Provider as your Authorized Representative).

## EXTERNAL REVIEW

If you receive an adverse benefit determination involving services or treatment subject to the *No Surprises Act* (see page 25), you may be able to seek review of your Claim by an Independent Review Organization (IRO). Because your TBT Plan is an Affordable Care Act "grandfathered plan," not all Claims—only adverse benefit determinations regarding compliance with the *No Surprises Act*—are eligible for this external review process.

**Here are the steps for seeking review by an IRO:**

- If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending. The Plan will consider your appeal through an expedited review process in this case.
- If the Trustees deny your appeal, you may, within four months of the date you were notified of the denied appeal, make a written request for an external review of your Claim by an IRO. Within five days of your request, the Plan will review your request to determine whether it is eligible for external review.

  Your Claim may not be eligible for review if you have not exhausted your internal appeal or your Claim involves a determination that you did not meet the eligibility requirements (for example, because an Employer did not pay a contribution on your behalf) or sought a benefit that was not covered by the Plan. The Plan will inform you of any issues regarding whether your request for review is subject to this process within one day of receipt of your review.

  If your request is eligible for review but incomplete, you will be informed about what information is required to complete the request and you will be given the longer of 48 hours, or the remainder of the four-month filing period, to correct the deficiency.
- If you request external review, your Claim will be submitted to an accredited IRO together with any documents and information the Plan and Trustees relied upon in considering your Claim and internal appeal. You will be informed by the IRO when it has received your Claim and provided 10 days to submit any additional information in support of your appeal. If you submit new information, the IRO will share that information with the Plan, which may elect to reconsider your internal appeal.

- The IRO will make independent medical and legal decisions concerning your Claim and issue its decision within 45 days of receipt of your Claim for review. If the IRO decides that the Plan must provide additional benefits, the Plan will carry out the decision but may challenge the decision by suing any necessary parties. If the IRO determines that the internal appeal was correctly decided, and you disagree with that decision, you may bring legal action against the Plan; but if you do so, the Plan provides that you must file your action in court no later than one year after receipt of notice of the IRO's decision.
- If your appeal involves (a) a medical condition when the timeframe for completion of a standard external review would seriously jeopardize your life or health, or ability to regain maximum function and you previously requested an expedited appeal to the Trustees, or (b) an admission, availability of care, continued stay or health care item or service for which you received Emergency Services, but have not been discharged from a facility, you may request expedited external review. If it is eligible for expedited review, your Claim will be referred as soon as possible to an IRO, and you will be informed of the IRO's decision as expeditiously as possible, but in no event longer than 72 hours after the IRO receives the Claim for review. If the initial notice is not in writing, you will receive written confirmation of the decision within 48 hours of the initial notice.

You are not required to seek external review by an IRO and may instead challenge the Trustee's denial of an appeal by bringing legal action against the Plan, but if you do so you must bring your lawsuit **no later than one year from the date you have received notice of an adverse determination.**

## RIGHT TO SUE

A lawsuit to obtain benefits is 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.

If you file a Claim and it is denied, and you appeal that denial to the Board of Trustees and that appeal is denied, you have up to **one year** after you receive notice of the denial of your appeal to sue the Trust over the denial of your Claim.

Any suit filed later than this 12-month deadline will be considered untimely. Any suit against the Plan, the Trust or the Board of Trustees for denial of a Claim **must be filed in the U.S. District Court for the Northern District of California** (located in Eureka, Oakland, San Francisco and San Jose, California).

## FILING FOR AND APPEAL OF DISABILITY CLAIMS

If you become Totally Disabled and want to extend benefits based on that disability (see *Extension of Coverage While Totally Disabled* starting on page 12), you must send a Claim for extended eligibility and evidence of your disability to the TBT Plan Administration Office.

A "disability claim" is any Claim where your eligibility for the benefit requires the Plan to determine whether you are "disabled." This would apply to the following kinds of Claims:

- Appeal of the denial of extension of coverage for the Plan participant and their Dependents for up to three months when Employer-paid coverage ends because the participant is Totally Disabled.

### *Claims and Appeals Timetable*

The timeline described in this section for filing and appealing Claims is summarized in the table below.

| Time Limits | Urgent Care Claim | Pre-Service Claim | Determination | Extension |
|---|---|---|---|---|
| *For Plan 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 the Plan's control) by Plan* | *None* | *15 days* | *15 days* | *30 days (two 30-day extensions possible)* |
| *For Plan to request missing information from claimant* | *24 hours* | *15 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* |
| *For Plan to make a 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* |

- For **certain plans only**, appeal of denial of a payment of "disability income benefits" of a specific amount per week for 26 weeks when the Plan participant is totally disabled. To find out whether your Plan includes this benefit, see your *Summary of Coverage* or contact the TBT Plan Administration Office).
- Extension of coverage for a Disabled Dependent child at age 26 or older (see page 6).

To apply for a disability benefit you need to request a *Disability Claim Form* from the TBT Plan Administration Office, complete the patient portion of the form, then give the form to your Physician to complete the health care Provider's section. Return the completed *Disability Claim Form* to the TBT Plan Administration Office (at their address listed on page 91).

**All disability Claims must be submitted to the TBT Plan Administration Office within 90 days from the date of onset of the Disability (or, in the case of a Disabled Dependent child, within 90 days prior to their 26th birthday). Plan benefits will not be paid for any Claim submitted after this period.**

The TBT Plan Administration Office will determine your disability benefits Claim no later than 45 calendar days after receipt. You will be notified if you did not follow the disability Claim process or if you need to submit additional information or records to prove a disability benefits Claim; and you have up to 45 calendar days to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the TBT Plan Administration Office determines that an extension is necessary due to matters beyond its control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period that additional time is needed to process the Claim, the special circumstances for this extension and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the TBT Plan Administration Office determines that, due to matters beyond its control, a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days—provided you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A *Notice of Extension* will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. If the TBT Plan Administration Office needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

The Plan will provide you, free of charge, with any new or additional evidence that is considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with the Claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date when the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

**If the Claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

**If the Claim for disability benefits is denied** in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

1. Give the specific reason(s) for the denial of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (a) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (b) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (c) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable).
2. Reference the specific Plan provision(s) on which the determination is based.
3. Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your Claim.
4. Describe any additional information needed to perfect the Claim and an explanation of why such added information is necessary.
5. Provide an explanation of the Plan's appeal procedure along with time limits.

6. Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal.
7. Describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one-year time limit on when a lawsuit may be filed following an appeal denial).
8. If the denial was based on an internal rule, guideline, protocol, standard or similar criterion, a statement will be provided that such rule, guideline, protocol, standard or criteria that was relied upon will be provided free of charge to you upon request.
9. If the denial was based on Medical Necessity, Experimental Treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you upon request, and
10. Include a statement that if a Plan participant is not proficient in English and has questions about a Claim denial, they should contact the TBT Plan Administration Office to find out if assistance is available.

**If you disagree with a denial of a disability Claim, you or your Authorized Representative may appeal as described below.** You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. You will be provided with:

1. Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your Claim for benefits.
2. The opportunity to submit written comments, documents, records and other information relating to the Claim for benefits.
3. A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination.
4. Automatically and free of charge, any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with the denied disability Claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
5. Before the Plan issues an Adverse Benefit Determination on review, any new or additional rationale for denial of your Claim. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.
6. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
7. A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual, and
8. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, Drug or other item is Experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:
   - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual, and
   - Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make an appeal determination according to the following timeframes:

1. **If an appeal is filed with the Plan *more than 30 days* before the next Board meeting**, the review will ordinarily occur at the next Board meeting.
2. **If an appeal is filed with the Plan *within 30 days* of the next Board meeting**, the Board review will ordinarily occur no later than the second meeting following receipt of the appeal.
3. If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide you with a *Notice of Extension* describing the special circumstances and date the benefit determination will be made.
4. After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

1. The specific reason(s) for the adverse appeal review decision of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable).
2. Reference the specific Plan provision(s) on which the determination is based.
3. A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your Claim.
4. A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal.
5. A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one-year time limit on when a lawsuit may be filed following an appeal denial).
6. If the denial was based on an internal rule, guideline, protocol, standard or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request.
7. If the denial was based on Medical Necessity, Experimental Treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
8. A statement that if you are not proficient in English and have questions about disability benefits, filing a Claim for disability benefits or about a Claim denial, you should contact the TBT Plan Administration Office for assistance.

   The TBT Plan Administration Office will provide notification regarding your appeal in a culturally and linguistically appropriate manner.

   The Plan will provide notices in non-English languages if **10%** or more of the population in any county where the Plan sends notices is literate only in the same non-English language. This includes providing oral language services (such as a phone hotline) that allow you to receive answers to your questions in a non-English language, providing written notices in a non-English language upon request and written statements in the English version of Plan notices indicating how you may access these language services.

# 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 PPO Contract Rate or 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 no other Group Plan was involved.

## HOW COORDINATION WORKS

If you or any covered Dependents have benefits through Group Plans including TBT, one of the two or more plans involved is the "primary" plan and all the other plans are "secondary."

The primary plan pays benefits first—as if no other Group Plans are involved. Then, the secondary plans coordinate payments so that the total paid by all plans is 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 semi-private Hospital room and the cost of a private Hospital room is not a Covered Expense, unless use of a private Hospital room is considered Medically Necessary as generally accepted health care practice for the condition for which you are 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 the patient directly (for example, covering you as an Employee rather than as someone's Dependent) is primary. However, if you are a Medicare beneficiary—and under Medicare's rules your coverage is secondary to a plan that covers you as a Dependent—and primary to a plan covering you directly (for example, covering you as an Employee or a retiree), the plan covering you as a Dependent is primary.
3. A plan is also primary if it covers a patient as an active Employee or as the Dependent of an active Employee, and secondary if it covers the patient as a retiree, a laid-off Employee or a Dependent of a retiree.
4. If you or an eligible Dependent are enrolled in COBRA coverage through a TBT Plan, any group health plan covering you as an active employee, or an eligible Dependent of an active employee, will be primary. Your COBRA coverage from this Plan will be secondary. If the other plan does not have a similar rule, or if the plans' rules conflict, this rule will be disregarded.
5. If both you and your Spouse are covered as active Employees under a TBT Plan, your Dependent Children will be enrolled as Dependents of both parents. However, the total benefit payments cannot be greater than **100%** of the Dependent child'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.
9. When Rules 1-8 do not establish which plan is primary and which plan is secondary, the plan that has covered the patient the longest is primary to the plan that has covered the person for a shorter length of time.

Regardless of whether this Plan is considered primary or secondary, if you or a Dependent are (a) covered by the indemnity portion of this Plan, (b) enrolled in an HMO (including any prepaid health coverage) under another group health plan, and (c) incur expenses normally covered under the HMO, Plan coordination will be limited to reimbursement of Copayments required by the HMO, and only if such Copayments are required of every person covered by that HMO.

If your TBT coverage is secondary and your primary plan denies your Claim for benefits because you have elected to receive treatment from a Provider or facility outside your primary plan's Preferred Provider Organization (PPO) Network, TBT will coordinate benefits as though received from the primary plan under the primary plan's normal level of payment for Non-PPO Hospitals or Doctors. *However, if the primary carrier denies a Claim as a non-covered service under their plan, TBT will apply its normal processing guidelines.*

## End Stage Renal Disease (ESRD)

ESRD coordination may differ and is subject to federal guidelines. If you or your Dependents are eligible for Medicare because you have End Stage Renal Disease (ESRD), the Plan is primary for the first 30 months of treatment for ESRD; then Medicare is primary. Contact the TBT Plan Administration Office if you have questions about ESRD coordination.

## Medical Benefit Payments

Medical expenses should be filed with the primary plan first, so it starts paying benefits immediately. The primary plan pays benefits *before* the secondary plan—just as if the primary plan is the only medical coverage.

Once the primary plan pays its maximum benefit, any secondary plan coordinates its benefits under its 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 specific rules regarding use of Preferred Providers and may have different benefit levels and maximum amounts.

If the primary plan has paid benefits under a PPO agreement, the TBT Plan will make additional payments only if under the primary plan you are obligated to make a Coinsurance payment (a Copayment or a Deductible) for the Claim. 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 was the primary payer. Because PPO Providers have agreed to accept contract rates, the total benefits paid by all plans should not exceed the maximum payment required by the lowest contract rates.

If your TBT coverage is secondary and your primary plan denies your Claim for benefits because you have elected to receive treatment from a Provider or facility outside of your primary plan's Preferred Provider Organization (PPO) Network, TBT will coordinate benefits as though you received benefits from the primary plan under the primary plan's ordinary level of payment for PPO Network Hospitals or Doctors.

To make sure you receive maximum benefits, it is 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.

*Coordination of Dental, Vision Care and Prescription Drug Payments.* Dental, vision care and prescription drug coverage 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 described for the Indemnity Medical Option beginning on page 66.

*Prepaid Dental Coordination.* If you are enrolled in a prepaid 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 prepaid 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).

***Coordination with Medicare.*** If you are an active Employee covered by both Medicare and the Indemnity Medical Option, your TBT Plan is the primary plan for you and your covered Dependents. This means that the Plan will determine its benefits without regard to whether you have coverage under Medicare.

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. If you or your Dependent are eligible for Medicare because you have End Stage Renal Disease (ESRD), see page 67.

## RIGHT TO RECOVER BENEFITS

The 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, the Trust has the right to recover any amount overpaid to 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 repay the overpaid amount to the Plan, the Trust may elect to recover the overpayment by deducting it from any future benefits payable to you or assigned by you. The Trust also has the right to make restitution to another plan that has overpaid, and this payment is considered a benefit under the TBT Plan since the payment was 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 any persons to or for whom such payments were made, or from any insurance companies or any other plans or organizations.

If the Board of Trustees, in its discretion, elects not to follow these rules for any particular Claim, this does not affect the right to invoke these rules for any other past or future claims.

Based on the specific circumstances related to how a Claim is filed, if the Plan pays 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*

TBT reserves the right to recover Claim payments made under any of its Plans on behalf of a Plan participant 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 Fund in full for any Claims paid relating to such injury or illness. If you are paid any amount from a Third Party for purposes of injuries to you caused by a Third Party and fail to repay the Fund for the Claims it has paid related to your injuries, the Plan can deduct the amount paid from any of your future benefit Claims as an offset.

*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 motorists" 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.

***The Plan will pay 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 under the Plan to have agreed to each of the following conditions:***

- That the Trust has established an equitable lien on any recovery received by you (or your Dependent, legal representative, trustee or agent).
- To notify any Third Party responsible for your illness or injury of the Trust's right to reimbursement for any Claims related to your illness or injury.
- To hold any reimbursement or recovery received by you (or your Dependent, legal representative, trustee or agent) in trust on behalf of the Trust to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Trust Fund promptly for the benefits paid, even if you or your Dependent are not fully compensated ("made whole") for your losses.
- That the Trust has the right of first reimbursement against any recovery or other proceeds of any Claim against the other person (whether or not you or your Dependent is made whole) and that TBT's Claim has first priority over all other Claims and rights.
- To reimburse the Trust 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 by 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 Trust as reimbursement up to the full amount of benefits paid.
- That the Trust's Claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise.
- That the Trust's Claims shall not be reduced under the doctrine of contributory or comparative negligence.
- That, in the event you elect not to pursue Claims against a Third Party, the Trust shall be equitably subrogated to your right of recovery and may pursue your Claims.
- To assign, upon TBT's request, any right or cause of action to TBT.
- Not to take or omit to take any action to prejudice the Trust's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Trust in obtaining reimbursement.
- To cooperate in doing what is necessary to assist the Trust to recover the benefits paid or in pursuing any recovery, **including timely submission of the Trust's Third-Party lien form and accident questionnaire** and keeping the Trust apprised of the progress of a trial, settlement or disposition of your Claim.
- To forward any recovery to the Trust within 10 days of disbursement by the Third Party or to notify the Trust as to why you are unable to do so, and
- To consent to the entry of judgment against you (and, if applicable, your Dependent, legal representative, agent, trustee or trust) in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over, as required, and for the cost of collection, including but not limited to the Trust's attorney's fees and costs.

If you or your Dependents fail or refuse to assist the Trust in recovering damages from a Third Party **(including failure to submit the Trust's Third-Party lien form and accident questionnaire)**, then TBT may:

- Not pay your Claims for medical care related to your Third Party claim.
- Offset what is paid on your and/or your Dependents' future Claims against the Claims paid for which the Trust should have been reimbursed because of the illness or injury caused by the Third Party until the Trust is completely reimbursed for the cost of these Claims (including but not limited to costs incurred in collection).
- File a lawsuit against you or your Dependents to fully recover the amount the Trust should have been reimbursed, and/or
- Take any other action deemed appropriate by the Board of Trustees.

If you or your Dependents receive no payment of any kind from a Third Party to reimburse you for an illness or injury caused to the Third Party, you do not have to reimburse the Trust for any benefits properly paid to you or your Dependents and, if you do receive payment from the Third Party, you do not have to pay the Trust more than the amount the Third Party paid to you or your Dependents.

If you have questions about how to comply with these Third Party liability rules, contact the TBT Plan Administration Office.

### *Right of Reimbursement and Recovery*

The 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 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.

## WORKERS' COMPENSATION

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

Your Plan does not replace any requirement for coverage by Workers' Compensation. However, the Plan may pay benefits for any Accidental 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 provisionally, 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 beginning on page 68.

## 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 85 for the Plan's full definition of a *QMCSO*.)

When the 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*.

Your Collective Bargaining Agreement may provide for coverage under one or more supplemental benefit plans. If so, these supplemental plans are separately funded and are not part of the benefit plan explained in this *Guide*. If you are eligible for such benefits, you will receive separate information about your supplemental benefit coverage.

## Board of Trustees

At the time this *Guide* is printed, there is an equal number of Union Trustees and Employer Trustees. In the future, there may be times when there are more Union Trustees than Employer Trustees. However, under the terms of the 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 listed on this page. To see the most current list, visit www.tbtfund.org.

### *Union Trustees*

**Carlos Borba**
**(Union Trustee Co-Chairman)**
Vice President
Teamsters Local Union No. 315
445 Nebraska Street
Vallejo. CA 94590-3830

**Steve Beck**
Secretary-Treasurer
Teamsters Local Union No. 853
7750 Pardee Lane
Oakland, CA 94621-1497

**John Bouchard**
Secretary-Treasurer
Teamsters Local Union No. 350
Cedar Hill Office Building
295 89th Street, Suite 304
Daly City, CA 94015-1656

**Sal Lomeli**
Secretary-Treasurer
Teamsters Local Union No. 439
1531 East Fremont Street, Suite 5
Stockton, CA 95205-4458

**Steven Lua**
President
Teamsters Local Union No. 853
7750 Pardee Lane
Oakland, CA 94621-1497

**Alberto Ruiz**
President
Teamsters Local Union No. 315
2727 Alhambra Avenue
Martinez, CA 94553-3120

### *Employer Trustees*

**Keith Fleming**
**(Employer Trustee Co-Chairman)**
Chairman of the Board
IEDA
2200 Powell Street, Suite 1000
Emeryville, CA 94608-1809

**William Albanese**
Central Concrete Supply
755 Stockton Avenue
San Jose, CA 95126-1839

**Gerald Coleman**
Labor Relations Manager
North California District
United Parcel Service (UPS)
12137 Wistar Way
Rancho Cordova, CA 95742-8237

**Richard Jordan**
c/o Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

**Richard Murphy**
c/o Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

**Bill Rossi**
c/o Teamsters Benefit Trust
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

## Plan Information

This information applies to all the Plans explained in this *Guide*. Information about HMOs and prepaid dental benefits may be found in separate disclosure materials from the Providers including *Evidence of Coverage* brochures. Contact the TBT Plan Administration Office if you need these materials.

## Plan Administration

The Plan Administrator is the joint Board of Trustees for the Teamsters Benefit Trust, which contracts with Titan Insurance Administrators, Inc., for certain 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 may also be served on any member of the Board of Trustees.

**Chris Vlach**
**Fund Manager**
**Teamsters Benefit Trust**
**39420 Liberty Street, Suite 260**
**Fremont, CA 94538-2200**

## Employer Identification Number

EIN 94-2848389.

The Plan identification number is 501.

## Type of Plan

The 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 may also provide disability and accidental death and dismemberment benefits for certain TBT Plans (as explained in your *Summary of Coverage*).

## 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 beginning on page 4.

***Note:*** *TBT Hour Bank Plans may have additional eligibility provisions that affect participation which are not described in this* ***Guide****. These additional eligibility provisions are explained in a* ***Supplement to the Guide to Your Benefits for Plans with Hour Bank Eligibility****.*

Contributions made by participating Employers are determined by the TBT Board of Trustees under the authority of the Collective Bargaining Agreements providing for participation in the Trust and TBT Trust Agreement.

## 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 directly by the Trust, unless you have enrolled for Hospital and medical benefits with an HMO, in which case TBT pays the HMO's monthly premiums and the HMO funds the benefits. Prescription drug benefits are administered by Anthem CarelonRx and Accredo (for Specialty Drugs) and are paid directly by the Trust. Some TBT Plans require Kaiser enrollees to use a Kaiser pharmacy (as explained in the *Summary of Coverage*). 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 paid by these organizations (currently Bright Now! Dental and United Healthcare 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 (if applicable to your Plan) are provided through an insurance policy with Prudential Life Insurance of America. Addresses for the current HMOs, Anthem CarelonRx, Accredo, Delta Dental, Bright Now! Dental, United Healthcare Dental, VSP and Prudential Life Insurance of America are listed on page 91. Keep in mind that this information may change. Contact the TBT Plan Administration Office if you need help contacting a Provider.

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

## Plan Year

The Plan's 12-month fiscal year for recordkeeping 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 the 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 changes or Plan amendments may change benefit levels, eligibility requirements or any other provisions 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 the Fund and the Plans. It also gives the Board of Trustees the power to construe and interpret the rules of the Plan and the Trust Agreement relating to the eligibility of Employees, their Dependents and beneficiaries to receive benefits.

The Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply, interpret and/or terminate any provisions of the Plan, this *Summary Plan Description/Plan Document*, and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan.
- Formulate, interpret and apply rules and policies necessary to administer the Plan in accordance with its terms.
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan.
- Resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents.
- Process, and approve or deny, benefit Claims, and rule on any benefit exclusions, and
- Establish, maintain and modify, in their complete discretion, policies for purposes of investment of Plan assets.

All determinations made by the Trustees with respect to any matter arising under the Plan or this *Summary Plan Description/Plan Document* shall be final and binding on all parties.

***Only the full Board of Trustees is authorized to interpret the Plan of Benefits described in the SPD and no individual Trustee, Union representative or Employer representative is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board.***

***The Board of Trustees has authorized the Plan Administrator to respond in writing to written inquiries from Plan participants. As a convenience to participants, the TBT Plan Administration Office will provide oral answers regarding coverage on an informational basis. However, no such oral communication is binding upon the Board of Trustees.***

## 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 will be non-taxable for federal income tax purposes.

## ERISA Rights Statement

The statement below is a summary of your rights as a Plan participant under ERISA.

As a participant in the TBT 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*

Examine, without charge, at the TBT 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.

### *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 health and welfare benefits or exercising your rights under ERISA.

### *Enforce Your Rights*

If your claim for a 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. Under the terms of the Plan, you must file such a lawsuit within 12 months from the date your appeal was denied by the Board of Trustees. (See *Right to Sue* on page 62.) 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 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 phone 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

Federal law prevents group health plans and health insurance issuers from restricting 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 longer than 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 Plan Description. Contact the TBT Plan Administration Office for more information.

# Your Health Information and Privacy

The Plan may use your health information, that is, information that constitutes Protected Health Information (PHI) 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 established a policy to guard against unnecessary disclosure of your health information.

**Here is a summary of the circumstances under which and purposes for which your 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 (PHI) over the phone 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 PHI 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 *Guide* (see page 78).

*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 you with information about 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.* TBT is a jointly trusteed multiemployer Trust Fund that contracts with a Third-Party administrator for the day-to-day administration of the Plan. TBT's Board of Trustees—not your Employer or Union—is the Plan sponsor. The Plan sponsor itself has no Employees. As the Plan Sponsor, TBT represents that adequate separation exists between the Plan and Plan Sponsor so that PHI will only be used for Plan administration.

The Plan may disclose your health information to the Board of Trustees for Plan administration functions performed by the Board of Trustees on behalf of the Plan, as described in 45 C.F.R. § 164.504(a), to the extent permitted under HIPAA regulations. Such administration shall include, but is not limited to, the following purposes: Appeals of Adverse Benefit Determinations, arranging for legal services, financial oversight, data analysis, COBRA administration, Coordination of Benefits and Plan design.

The Plan also may provide summary health information to the Board for the purpose of soliciting bids from health care providers and service plans or for the purpose of modifying, amending or terminating the Plan.

The Board of Trustees will not use or further disclose your PHI other than as permitted or required to carry out these purposes, or as otherwise required by applicable law. The Plan will not use or disclose your PHI for marketing purposes or in exchange for payment.

As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Plan, the Plan sponsor agrees:

- To use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- To require each of its subcontractors or agents to whom the Plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the Plan sponsor with respect to PHI.
- To bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plans sponsored by the Plan sponsor, or an entity appointing a member of the Board of Trustees, such as a Union, Employer or employer association, and not use or disclose the PHI for employment-related actions of an entity appointing a member of the Board of Trustees, such as a Union, Employer or employer association.
- To report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- To make your PHI available for purposes of your request for inspection or copying.
- To make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete, and to incorporate such amendments as is allowed under the Privacy Rule.
- To make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- To make its internal practices, books and records relating to the use and disclosure of PHI 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, to return to the Plan or destroy all PHI received from the Plan in any form and not to retain 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.
- To use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

*When Legally Required.* The Plan discloses your PHI 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 PHI 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 PHI 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 PHI 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 Workers' Compensation.* The Plan may release your health information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.

*In the Event of Your Death.* If the individual is a decedent, the Plan may disclose the decedent's PHI (other than information about past, unrelated medical problems) to the decedent's family members and others who were involved in the care or payment for care of the decedent prior to the decedent's death, unless doing so would be inconsistent with any prior expressed preference of the individual that is known to the Plan.

*For Underwriting and Related Purposes.* The Plan may use or disclose your health information for the purposes of underwriting, premium rating or other activities relating to the creation, renewal or replacement of health insurance, but is prohibited from using or disclosing your genetic information for such purposes.

## Authorization to Use or Disclose Health Information

Other than as stated in this section, 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 PHI 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, 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 phone number or by email. If you wish to receive confidential communications, 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 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, contact the Privacy Officer at the TBT Plan Administration Office.

*Right to Choose Someone to Act for You.* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights as explained in this section and make choices about your health information. The Plan will make sure that the person has this authority and can act for you before taking any action.

## 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**
**Phones: (510) 796-4676**
**or (800) 533-0119**
**email: info@tbtfund.org**

## Effective Date

The Plan's privacy policies and procedures became effective April 14, 2003.

# Definitions

Here are definitions for important words used in this *Guide* with specific meanings. Throughout this *Guide*, these words are capitalized because they have specific meanings explained in this Definitions section. There are words defined here that may have a different meaning when used by one of your Plan's HMOs or prepaid dental options.

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

***Accredo.*** The organization currently selected by the TBT Board of Trustees as the Pharmacy Benefit Manager (PBM) to administer Specialty prescription drug benefits.

***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, or if it rescinds your coverage altogether, you are sent a *Notice of Adverse Decision* that includes the information described on page 58.

***Adverse Decision on Appeal.*** If you appeal an Adverse Decision, you receive a *Notice of Adverse Decision on Appeal* that contains all information described on page 61.

***Allowed Amount.*** The amount the Plan will pay for covered services. This is the PPO Contract Rate for services incurred in-network, or the UCR amount for services incurred out-of-network.

***Anthem Blue Cross.*** The Preferred Provider Organization (PPO) which also administers procedures such as Pre-admission Certification, Utilization Review, Concurrent Review and Case Management services for the Indemnity Medical Option.

***Anthem Blue Cross PPO Network.*** The Indemnity Medical Option's PPO for Hospitals, Doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health and alcohol or chemical dependency treatment Providers and other Providers.

See the Anthem website at www.anthem.com/ca to find current Providers in the PPO Network. You can also check whether a Provider is in the PPO Network by calling Anthem Blue Cross at (888) 887-3725.

***Anthem CarelonRx.*** The organization currently selected by the TBT Board of Trustees as the Pharmacy Benefit Manager (PBM) to administer prescription drug benefits.

***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.

***Balance Billing.*** A situation when a Non-PPO Provider bills you for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is **$100** and the Allowed Amount is **$70**, the Provider may bill you for the balance of **$30**. This balance-billed amount would be in addition to your Coinsurance and would not count toward your Out-of-Pocket Limit.

***Blue Cross Blue Shield National Network.*** The PPO Network used by TBT for Indemnity Medical Plan participants living outside California.

***Carryover Rule.*** This rule allows you to "carry over" any Covered Expenses you have in the last three months of the year applicable to your Plan Deductible into the next calendar year and apply them to the Deductibles for that year. **This rule applies to all TBT Plans except Plan IV.**

***Chemical Dependency Recovery Hospital (CDRH).*** In California, this refers to a Hospital licensed to provide 24-hour inpatient care for dependency on alcohol or other drugs.

***Children.*** Children include:

- Son and daughter.
- Stepchild.
- Legally adopted child.
- Child placed with you for adoption.
- Child for whom you and/or your Spouse are the legally appointed guardian.
- Child of your legally qualified Domestic Partner.
- Person for whom you are required to provide dependent health coverage as the result of a Qualified Medical Child Support Order (*QMCSO*, explained on pages 70 and 85).

Generally, Children are covered up to age 26. See page 6 for rules related to a child who became disabled while covered. Also see *Who Is Eligible as a Dependent Child?* on page 6.

***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 claim filing procedures. Your Plan has several definitions related to different types of Claims. See *Claiming Benefits* beginning on page 55.

***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. See pages 14-20 for more information.

***Coinsurance.*** Your share of the costs of a covered health care service, calculated as a percentage (for example, **20%**) of the Allowed Amount for the service. You pay Coinsurance plus any Deductible amounts you owe. For example, if your TBT Plan's Allowed Amount for an office visit is **$100** and you have met your Deductible, your Coinsurance payment of **20%** would be **$20**. The Plan pays the rest of the Allowed Amount for the service. Your Coinsurance share ends when you have paid your *Out-of-Pocket Maximum* for the calendar year.

***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 that have been approved by the Board of Trustees for participation in the Trust.

***Convalescent Care Facility.*** (See *Skilled Nursing Facility* on page 30.)

***Conversion Policy.*** An individual life insurance policy that is converted from a TBT group policy when it ends. See pages 53-54 for more information.

***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. See *Coordination of Benefits* beginning on page 66 for more information.

***Copayment.*** A fixed amount ($20, for example) you pay for a covered health care service after you have paid your Deductible. Copayments (sometimes called "copays") can vary for different services within the same Plan, like office visits, prescription Drugs, lab tests and visits to Specialists. Check your *Summary of Coverage* for details.

***Cosmetic.*** Any treatment or procedure primarily to improve a person's appearance.

***Covered Expense (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 greater than what Delta Dental determines exceed UCR charges for a similar procedure in your geographical area are not covered. For example, if your Dentist charges **$100** for a procedure for which the UCR is **$80**, the Plan will pay its share of the **$80**, but the **$20** exceeding UCR is your obligation.

***Covered Expense (under the Indemnity Medical Option).*** An expense for Hospital, medical, surgical, prescription drug, dental, orthodontic or vision care services or supplies provided by and not subject to any exclusions under the Plan based on either the PPO Contract Rate (for expenses incurred with PPO Providers) or UCR (for expenses incurred with Non-PPO Providers).

***Covered Services (under the Indemnity Dental Option).*** The specific dental service covered according to the Plan's 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. Not all services are subject to the Deducible (for example, many Preventive Care services).

***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 or qualified Domestic Partner, your Children under age 26 and Children older than age 26 with permanent and Total Disability that existed prior to reaching age 26. To qualify for this disability extension, the child must (1) be unmarried, (2) have been eligible for and enrolled in the Plan in the month of their 26th birthday, (3) be permanently and totally disabled (for example, the disability has lasted 12 months and is expected to last 12 months or for life), (4) the disability must have existed prior to the child's 19th birthday, and (5) rely chiefly upon the Participant for support or maintenance.

A child whose coverage has terminated due to reaching the age limit and who then becomes disabled cannot re-enroll as a disabled adult Dependent child.

Dependent Children do not include foster children, the Spouse of a Dependent child (such as your son-in-law or daughter-in-law) or a child of a Dependent child (such as your grandchild) unless you or your legal Spouse or Domestic Partner have been appointed the grandchild's legal guardian. See pages 4-6 for detailed requirements.

***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:** For purposes of COBRA eligibility related to a disability, a special definition of disability applies. See Disability Extension on page 19.

***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, "Doctor" may not include your Spouse, Domestic Partner or someone with whom you live.

***Domestic Partner.*** Domestic Partners are defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. There are no requirements for Domestic Partners for proof of relationship or waiting periods that are not also applied to married couples.

***Drug.*** 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. See *Your Prescription Drug Benefits* beginning on page 36 for more information on covered prescription Drugs.

***Durable Medical Equipment (DME).*** Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses. DME consists of items which

are (1) primarily and customarily used, (2) to serve a medical purpose, (3) are not useful to a person in the absence of illness or injury, (4) are ordered or prescribed by a Physician, (5) are reusable, (6) can stand repeated use, and (7) are appropriate for use in the home. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

***Emergency Medical Condition.*** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that in the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

***Emergency Medical Transportation.*** Ambulance services for an Emergency Medical Condition.

***Emergency Room Care.*** Emergency Services administered in an emergency room.

***Emergency Services.*** An appropriate medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to determine whether an Emergency Medical Condition exists; whether an Emergency Medical Condition exists; and whether such further medical examination and/or treatment may be required to stabilize the Emergency Medical Condition.

***Employee.*** A person (1) employed under the terms of a Collective Bargaining Agreement between a Union and an Employer or a person who is covered by an Adoption Agreement, and (2) who satisfies the definition of "employee" as defined by the state law of the state in which he or she resides (or, if applicable, under the law of the District of Columbia).

***Employer or Participating Employer.*** An Employer or Employer organization that has a Collective Bargaining Agreement with a local Union (or multiple locals) affiliated with the International Brotherhood of Teamsters or directly 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 accommodations, services, supplies, or other items or combination of the foregoing that are determined by the Trust 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.
- For which the required approval of a governmental agency has not been granted at the time the services are rendered, or
- Under investigation or limited to research by the federal Food and Drug Administration (FDA), the American Medical Association (AMA) Diagnostic and Therapeutic Technology Assessment (DATTA) or the Office of Medical Application of Research of the National Institute of Health Office of Disease Prevention (ODP).

However, if a treatment has not been addressed by one of the organizations listed above, the Plan may determine if a treatment is appropriate based on the advice of its medical review and/or the review of an independent medical reviewer or other medical experts.

The Trust (or its designee) will make such determination. To determine whether a particular accommodation, service, supply or other item is Experimental, the Trust (or its designee) may review established preauthorization procedures and refer to the current applicable literature and federal and state laws and regulations and consider any other information it deems relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned parties.

***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.

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

***Health Maintenance Organization (HMO).*** A health care organization (such as Kaiser or the Anthem Blue Cross HMO) that covers only services and supplies received from HMO member Providers and HMO facilities.

***Home Health Care.*** Health care services a person receives at home.

***Hospice Services.*** 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 the attending Doctor and appropriate personnel of a hospice care agency.

***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 and alcohol or chemical dependency, or tubercular facilities certified by the American Hospital Association. Rest homes and convalescent homes are not Hospitals.

***Hospitalization.*** Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be Outpatient care.

***Hospital Outpatient Care.*** Care in a Hospital that usually does not require an overnight stay.

***Indemnity Dental Option.*** Dental benefits provided by the Plan as described in this *Guide*, your *Summary of Coverage* and *Comparison of Dental Benefits*.

***Indemnity Medical Option.*** Medical benefits provided by the Plan as described in this *Guide*, your *Summary of Coverage*, *Comparison of Medical Benefits* and *Preventive Care and Wellness Benefits*.

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

***Maximum.*** See Out-of-Pocket Limit or Maximum.

***Medically Necessary or Medical Necessity.*** Services or supplies covered by your 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.*** Medi-Cal is California's Medicaid program. It is a public health insurance program which provides health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS. For more information about Medi-Cal, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx or call (916) 552-9200.

***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.

***Network (or PPO Network).*** The facilities, Providers and suppliers your Plan has contracted with to provide health care services (currently the Anthem Blue Cross PPO Network).

***Non-PPO Provider.*** A Provider that does not have a contract with the Indemnity Medical Plan's PPO Network to provide services to you. You generally pay more to see a Non-Preferred Provider. See Preferred Provider Organization (PPO) on this page.

***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 10.

***Orthodontia.*** Moving and/or straightening teeth to correct malocclusion.

***Out-of-Pocket Limit or Maximum.*** The most you pay during a calendar year before your health plan begins to pay **100%** of the Allowed Amount. This limit never includes balance-billed charges or health care that your Plan does not cover. See your *Summary of Coverage* for other charges that do not count toward your Out-of-Pocket Limit.

***Outpatient.*** Services performed without the need for a Hospital admission.

***Outpatient Surgical Procedures.*** Surgery ordinarily performed without overnight Hospitalization.

***PBM.*** Pharmacy Benefits Manager. An organization selected by the TBT Board of Trustees to administer prescription drug benefits.

***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.*** The TBT Plan of benefits named in the Collective Bargaining Agreement (and/or Adoption Agreement) between your Union and your Employer. 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*.

***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 under the Indemnity Medical Option maintained by the Anthem Blue Cross PPO Network.

PPO Providers agree to accept the PPO Contract Rate for services (see *PPO Providers* on page 22 which explains the Anthem Blue Cross PPO Network). They include Hospitals, Doctors, x-ray centers, clinical laboratories, physical therapy centers, chiropractors, mental health and alcohol or chemical dependency treatment Providers. (**Note:** If you live outside California, see *PPO Network for Non-California Residents* on page 26.)

***PPO Contract Rate.*** The amount that PPO Providers have contractually agreed to accept as payment for treatment and related services.

***Preventive Dental Care.*** Under the Indemnity Dental Option, Prophylaxis, routine exams and preventive services listed on pages 43-44.

***Preventive Care.*** Services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive Care does not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. See *Preventive Care Services* on page 23. For details about Preventive Care services that your Plan covers without cost-sharing, see the supplement to this *Guide* called *Preventive Care and Wellness Benefits*.

***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. At a minimum, the medical support order must contain the details below:

1. Name and last known address of the parent who is covered under the Plan.
2. Name and last known address of each child to be covered under the Plan.
3. A description of the type of coverage to be provided to each child named in the medical support order, and
4. The time period when the coverage is to be provided to each child.

***Review Organization.*** The Medical Review Organization selected by TBT (currently Anthem Blue Cross Life and Health) to administer required procedures such as Pre-admission Certification, Utilization Review, Concurrent Review and Case Management services for certain medical Claims (see pages 26-28).

***Skilled Nursing Care.*** Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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

***Specialist.*** A Physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions and is licensed and/or certified as a Specialist. A non-Physician Specialist is a Provider who has more training in a specific area of health care.

***Specialty Drugs.*** See pages 37-39.

***Spouse.*** A person who is legally married under state law to a Plan participant.

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

**Titan Insurance Administrators, Inc.**
**39420 Liberty Street, Suite 260**
**Fremont, CA 94538-2200**
**Local Phone: (510) 796-4676**
**Toll-Free: (800) 533-0119**
**Email: info@tbtfund.org**

***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). The Board of Trustees is the Plan Administrator designated under ERISA.

***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.*** The amount paid for a dental service in a geographic area based on what Providers in the area usually charge for the same or similar dental services, used by your TBT Plan to determine what it will pay when you use Non-PPO dental Providers. Any charges exceeding what the Plan has determined to be UCR will not count toward meeting applicable Deductibles, Copayments or maximums.

***Usual, Customary and Reasonable (UCR) under the Indemnity Medical Option.*** The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical services, used by your TBT Plan to determine what it will pay when you use Non-PPO medical Providers) other than the charges of a Non-PPO medical Provider subject to the No Surprises Act). Any charges exceeding what the Plan has determined to be UCR will not count toward meeting applicable Deductibles, Copayments or maximums.

***Utilization Review.*** Review of your treatment by the Plan's 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 Anthem Blue Cross.

***Vision Service Plan (VSP).*** The Plan's vision care Provider selected by the TBT Board of Trustees.

***You.*** As used in this *Guide* and your *Summary of Coverage*, the Plan participant.

# Index

This index helps you find information about common benefit topics. Broader subjects discussed in different sections may be cross-referenced.

# Phone Numbers and Addresses

## 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.

**Teamsters Benefit Trust (TBT) Plan Administration Office**

*Office Address*
39420 Liberty Street, Suite 260
Fremont, CA 94538-2200

*Website*
www.tbtfund.org

*Fax Number*
(510) 795-0680
**Do not send Claims by fax** unless the TBT Plan Administration Office requests that you do so.

*For General Emails Only*
- info@tbtfund.org

*For Claims Inquiries Only*
- Email: eobinquiry@titan-tpa.com
- Fax: (510) 795-0738

## TBT Provider List

A list of TBT Providers and reasons to call is printed on the next page. Refer to this list whenever you need to contact your TBT Providers.

## 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*
8:00 a.m. to 5:00 p.m. PT, Monday through Friday (except holidays).

*Customer Service Hours*
8:30 a.m. to 4:30 p.m. PT, 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 más información comuníquese con la Oficina de Administración del Plan TBT a la dirección que se encuentra en esta página.

*Horas de Oficina*
8:00 a.m. a 5:00 p.m. PT, Lunes a Viernes (excepto días feriados).

*Horas de Servicio al Cliente*
8:30 a.m. a 4:30 p.m. PT, Lunes a Viernes (excepto días feriados). El número de teléfono es **(510) 796-4676** o **(800) 533-0119**.

| Provider List | Phone Numbers | Address | Reasons to Call |
|---|---|---|---|
| **TBT Plan Administration Office**<br>www.tbtfund.org<br>email: info@tbtfund.org | (510) 796-4676<br>(800) 533-0119 | 39420 Liberty Street, #260<br>Fremont, CA 94538-2200 | TBT eligibility questions, enrollment forms (including HMOs), changes in family status, Open Enrollment forms, Employer contributions, Indemnity and PPO claims, disability waivers application, life and accidental death & dismemberment claims and other questions.* |
| **Accredo Specialty Pharmacy**<br>www.accredo.com | (833) 255-0645 or<br>(800) 803-2523 | P.O. Box 954041<br>St. Louis, MO 63195 | Handles delivery of preauthorized Specialty medications and refills.* See website for app. |
| **Anthem CarelonRx (Pharmacy Network)**<br>www.anthem.com/ca<br>Preauthorization Help Desk<br>Mail Service Program<br>Accredo Specialty Pharmacy | (833) 308-3034<br><br>(833) 293-0659<br>(833) 236-6196<br>(833) 255-0645 | P.O. Box 52065<br>Phoenix, AZ 85072-2065 | Anthem CarelonRx Pharmacy Program Customer Service Unit: Call (833) 308-3034 for Formulary and covered drugs questions, network pharmacies and Rx ID Cards. Contact TBT Plan Administration Office for other prescription-related service issues. |
| **Anthem Blue Cross Life & Health**<br>www.anthem.com/ca | (800) 274-7767 | P.O. Box 60007<br>Los Angeles, CA 90060 | Hospital Pre-admission Certification and Utilization Review or for appeals.* |
| **Anthem Blue Cross PPO Network**<br>www.anthem.com/ca | (888) 887-3725 | P.O. Box 60007<br>Los Angeles, CA 90060 | Find Preferred Providers In the Blue Cross PPO Network. Contact for appeals.* Order Anthem Blue Cross PPO ID Cards. See website for app. |
| **Anthem Blue Cross Blue Shield National Network (Outside CA)**<br>www.bcbs.com | (800) 810-2583 | P.O. Box 60007<br>Los Angeles, CA 90060 | Outside California: Find Preferred Provider Hospitals, PPO network physicians and other PPO providers.* |
| **Anthem Blue Cross HMO Plan**<br>www.anthem.com | (800) 227-3670 | P.O. Box 60007<br>Los Angeles, CA 90060 | Blue Cross HMO Plan benefit questions* Anthem website lists Network Physicians. Order Blue Cross HMO ID Cards or request to file an appeal. See Anthem website for app. |
| **LiveHealth Online (Indemnity Medical PPO only)**<br>www.livehealthonline.com | (888) 548-3432 | | Schedule phone or video telehealth visits with board-certified doctors that are not subject to Plan Deductible or Copayments. See website for app. |
| **Healthy Lifestyles (HMC HealthWorks)**<br>https://tbt.hmchealthworksco.com | (855) 888-2144 | | Health coaches and wellness resources for chronic medical conditions.* |
| **Kaiser Member Services**<br>www.kaiserpermanente.org | (800) 464-4000 | 1800 Harrison, 9th Floor<br>Oakland, CA 94612-2998 | HMO benefit questions.* Order Kaiser ID Cards. See Kaiser website for app. |
| **Delta Dental**<br>www.deltadentalca.org | (800) 765-6003 or<br>(888) 335-8227 | P.O. Box 997330<br>Sacramento, CA 95999-7330 | Dental Option 1 benefit questions.* For Delta Dental provider finder service or appeals, call (800) 427-3237 or visit the Delta Dental website. |
| **Bright Now! Dental Newport Option**<br>www.brightnow.org | (800) 497-6453<br>(714) 668-1300 | 8105 Irvine Center Drive<br>Irvine, CA 92618 | Dental Option 2 benefit questions, network provider questions and service issues.* |
| **United Healthcare Dental**<br>www.uhc.com/myhc | (800) 445-9090 | P.O. Box 30567<br>Salt Lake City, UT 84130-0567 | Dental Option 3 benefit questions, network provider questions and service issues.* |
| **Vision Service Plan**<br>www.vsp.com | (800) 877-7195 | P.O. Box 997100<br>Sacramento, CA 95899-0001 | Vision benefit questions, billing questions and network provider questions.* |
| **Teamsters Assistance Program (TAP)** | (510) 562-3600<br>(800) 253-TEAM | 300 Pendleton Way<br>Oakland, CA 94621-2109 | Alcohol or chemical dependency matters including inpatient programs in the San Francisco Bay Area.* |
| **Teamsters Alcohol/Drug Rehabilitation Program (TARP)** | (209) 572-6966<br>(800) 522-8277 | 1620 N. Carpenter Road, #C-12<br>Modesto, CA 95351-1158 | Alcohol or chemical dependency matters including inpatient programs in the Central Valley.* |
| **Prudential Life Insurance**<br>www.prudential.com | (800) 524-0542 | P.O. Box 1215<br>Newark, NJ 07101-1215 | First call the TBT Plan Administration Office. |
| **Western Conference of Teamsters Pension Trust Fund**<br>www.wctpension.org | (650) 570-7300<br>(800) 845-4162 | 355 Gellert Blvd., #100<br>Daly City, CA 94015-2666 | All WCT pension matters. |

* **Note:** *For general enrollment information, medical, HMO and dental option elections, address changes and changes in Dependent status, contact the TBT Plan Administration Office. Any required forms (including HMO change forms) are mailed to you by TBT. You may also download forms from the TBT website at www.tbtfund.org.*

*Teamsters Benefit Trust • Guide to Your Benefits*
*Grandfathered Plans I, I-85, I-A, III, III-A, IV, V and V-A*
*Revised July 2023 • Form Q1-D-GF—8-1-23*