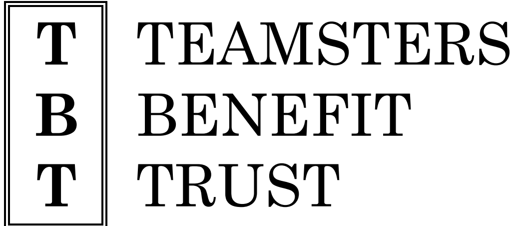

Post Office Box 5820
Fremont, California 94537

39420 Liberty Street, Suite 260
Fremont, California 94538

www.tbtfund.org

Telephone (510) 796-4676 • (800) 533-0119 • FAX (510) 795-0680

TEAMSTERS BENEFIT TRUST

Summary of

CHANGES TO PLAN VI

March 13, 2012

To: Active Employees and their Dependents, including COBRA beneficiaries:

The "Affordable Care Act" (popularly known as "Obamacare") signed into law in 2010 required changes in all group health plans. However some plans – "grandfathered plans" – are not required to make certain benefit changes and others – "non-grandfathered" plans – are required to make the changes described in this notice. You are being sent this notice because the Trustees have elected to make Plan VI "non-grandfathered", effective February 1, 2012. As participants in a "non-grandfathered" plan you will have benefits and rights that participants in the Trust's "grandfathered" plans do not have. **EXCEPT AS DESCRIBED IN THIS NOTICE, ALL OF YOUR BENEFITS REMAIN THE SAME AS THEY ARE DESCRIBED IN YOUR PLAN VI ENROLLMENT FOLDER. KEEP THIS NOTICE WITH YOUR PLAN FOLDER SO THAT YOU WILL HAVE IT WHEN YOU NEED TO REVIEW YOUR BENEFITS.** Until a new Summary Plan Description ("SPD") is printed, this notice together with the Plan VI *Summary of Benefits, Comparison of Medical Benefits, Comparison of Dental Benefits* and Plan VI *Guide to Your Benefits* will serve as the official Plan VI plan document. You should keep all your plan documents in a safe place for future reference.

CHANGES IN MEDICAL BENEFITS EFFECTIVE 2/1/2012

BENEFIT	Prior to 2/1/2012	On and After 2/1/2012
Coverage of Preventative Services	▪ Routine physical exams; ▪ Related x-rays and labwork; ▪ Routine mammograms; ▪ PSA tests for prostate cancer; ▪ Flu shots; and ▪ Routine Pediatric tests …are covered at 100% after $10 Co-pay with NO Calendar Year Maximum for routine physical exam, *and 80% for all other preventive care*, if you use a **PPO provider**; and at 80% of "UCR" with NO Calendar Year Maximum if you use a **Non-PPO Provider.** "UCR" = Usual, Reasonable & Customary charges	ALL OF THE PREVENTATIVE SERVICES ON THE LIST ATTACHED AT THE END OF THIS NOTICE, …are covered at 100% with no Co-pay, and with NO Calendar Year Maximum if you use a **PPO provider**; and are covered at 80% of "UCR" with NO Calendar Year Maximum if you use a **Non-PPO Provider.** "UCR" = Usual, Reasonable & Customary charges

BENEFIT	Prior to 2/1/2012	On and After 2/1/2012
Hospital Emergency Room Services	▪ **Inpatient (you are admitted to the hospital overnight after being treated in the Emergency Room):** 80% of PPO or 50% of UCR if Non-PPO Hospital. ▪ **Outpatient, *Non-Accidental Injury* (your condition is an emergency but not the result of an "accidental injury," you are treated in the Emergency Room and sent home):** 80% of PPO or 50% of UCR if Non-PPO Hospital. ▪ **Outpatient, *Accidental Injury* (your condition is an emergency and results from an "accidental injury," you are treated in the Emergency Room within 24 hours of the injury, and sent home):** 80% of PPO or 50% of UCR if Non-PPO Hospital. **Definition of "Emergency":** "The sudden, unexpected onset of symptoms or a medical condition that is severe enough to require immediate medical attention without which the person's health would be in jeopardy, there would be serious medical consequences, damage to bodily functions, or severe and permanent consequences to any bodily organ or part". **Definition of "Accidental Injury":** "Physical injury resulting from a sudden, violent and external force that was not expected and could not have been reasonably foreseen or avoided."	**Non-PPO hospitals will generally be paid at least as much as what would be paid if you used a PPO Hospital Emergency Room.** *In most cases, this will not be a material change in the pre-2012 reimbursement rate.* However, a hospital's billed charges frequently far exceed the Usual, Customary and Reasonable ("UCR") rates for those services. If you obtain emergency services from a non-PPO hospital, that hospital may still bill you directly for its charges that exceed what the Plan pays the hospital on your behalf (aka "balance billing"). You can avoid balance billing and will generally have lower out-of-pocket costs if you receive emergency services from a PPO hospital. **Definition of "Emergency":** "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part." **Definition of "Accidental Injury":** No change.

INTERNAL AND EXTERNAL APPEALS

Previously, if your claim was denied and you appealed to the Board of Trustees and your appeal was denied, there was no further appeal. **Effective February 1, 2012, if your claim is denied and you appeal to the Board of Trustees and your appeal is denied, you can seek review by an independent review organization ("IRO").**

- If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending.
- 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. Plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit or a determination that a particular type of treatment is experimental or investigational are eligible for external review. A decision to rescind coverage may be 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 Plan's eligibility requirements (e.g. 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 with your request within one day of completing its review. If your request is eligible for review, but incomplete, you will be informed 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 ten 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 reconsider your internal appeal.
- The IRO will make independent medical and legal decisions concerning your claim. The IRO will issue its decision within 45 days of receiving 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 bringing suit against 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 within one year of the IRO's decision.
- If your appeal involves (a) a medical condition where 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. The Plan will review your request immediately to determine whether it is eligible for external review. If it is eligible, 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 more 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 Trustees' denial of an internal review by bringing legal action against the Plan within one year of the date you are informed your appeal has been denied.

PLEASE NOTE

This Notice is intended to amend all TBT documents, notices and correspondence, including (but not limited to) Guide To Your Benefits and Summary of Coverage.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the *Guide To Your Benefits*. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

Si usted gustaria una copia en espanol, por favor de contactar
la oficina de administracion de Teamsters Benefit Trust.