



Western Teamsters Welfare Trust

INDEMNITY PLUS PLAN

Benefit Booklet and Summary Plan Description

Effective: September 1, 2018

INTRODUCTION

Dear Employees and Family Members:

This Booklet describes the Indemnity Plus Plan of the Western Teamsters Welfare Trust (the Trust). It contains the eligibility rules for the benefit options, the continuation options available through COBRA, the claims and appeal procedures used by the Trust and other information. It also includes the Summary Plan Description information required by the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits available through the Trust are funded by employer contributions as reflected in certain collective bargaining agreements including those negotiated by your Teamsters local union and your employer. The negotiated contributions are paid into the Trust which then provides your benefits. The Trust is managed by a joint labor-management Board of Trustees whose services are voluntary and without compensation from the Trust. The Board of Trustees designs and administers the benefit programs.

The Trust provides a comprehensive set of benefits. We encourage you to become familiar with your benefits and the valuable protection they offer you and your family.

The rules governing the plans are extensive and are explained in detail in the following pages. We urge you and your family to read this booklet carefully to become familiar with your benefit entitlements and how to obtain them.

The Trustees believe that the terms of the Plan fully comply with ERISA and all other applicable laws and regulations, and amendments thereto. The Plan will be administered in accordance with these laws and regulations.

The Trustees provide benefits to the extent that monies are currently available to pay the costs of these benefits. Benefits are not guaranteed to continue indefinitely. Pursuant to the terms of the underlying Trust Agreement, the Trustees are vested with the authority to determine the benefits to be provided and the conditions of eligibility, and to make such changes, on the basis of actuarial principles, as they may determine including, if necessary, termination of the Trust.

If you would like further information or assistance, please call or write the Trust Administrative Office. You will find the Trust Administrative Office contact information on page 115.

Sincerely,

Board of Trustees Western Teamsters Welfare Trust

Employer Trustees

Tom Walters, Co-Chair
John Coulson
William R. Davidson
A.J. Phillips
Doug Ruygrok

Union Trustees

Bob Paffenroth, Co-Chair
Justin "Buck" Holliday
Patrick Kelly
Walter Maestas
Michael Simone

Address Questions to the Trust Administrative Office: All questions about Plan participation, eligibility for benefits, and the nature and amount of benefits, should be referred to the Trust

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Administrative Office. Only the Board of Trustees, the Trust Administrative Office, or the Principal Trust Office, is authorized to answer questions concerning the Trust and its benefit plans. No participating employer, employer association, labor organization, or any individual employed thereby has any authority to give plan information.

Future Amendments: This Plan Booklet and Summary Plan Description are complete and up-to-date as of September 1, 2018. Future amendments will be published in the form of inserts which you should keep in the pocket on the inside of the back cover.

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IMPORTANT NOTICES

PPO Providers

For its self-funded medical plans the Trust contracts with Anthem to obtain access to certain PPO Providers. These are Preferred Facilities and Preferred Professional Providers who have agreed to accept a negotiated amount for various services provided to Participants. To encourage use of PPO Providers, the indemnity medical plans will pay a higher percentage of Covered Expenses after the annual deductible is met if a PPO Provider is used. Additionally, a Participant will normally not be responsible for any charges for Covered Expenses above the negotiated rate when services are provided by a PPO Provider.

Blue Distinction Centers for Specialty Care

Under the Trust's indemnity medical plans Bariatric surgery and transplants must be performed in Blue Distinction Centers for Specialty Care. For more information about this program, please see page 30 of this Booklet or contact the Trust Administrative Office.

Non-PPO Ambulatory Surgical Centers

The Trust's indemnity medical plans have a \$1,000 daily benefit limit on facility charges for Non-PPO ambulatory surgical centers. This limit does not apply to PPO ambulatory surgical centers.

Non-PPO Laboratory Claims

Effective with claims incurred on or after September 1, 2018, benefits under the Trust's indemnity medical plans for non-PPO laboratory claims will be limited to a maximum of \$300 per date of service. This limit does not apply to PPO laboratory claims.

Need to Apply for Retiree Medical Coverage

The Western Teamsters Welfare Trust maintains a Retiree Medical Plan for eligible employees and their dependents. Eligible individuals must apply to the Retiree Plan within 90 days of the later of your Western Conference of Teamsters pension effective date or the end of your coverage under the Western Teamsters Welfare Trust. Please be aware that this application must be submitted to this Trust and is separate from your pension application. If you have questions, contact the Trust Administrative Office.

Grandfathered Status

This plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

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Being a grandfathered health plan means that our plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, i.e., the requirements for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, i.e., the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office. You may contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or visit the website at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

BENEFITS DESCRIBED IN THIS BOOKLET

FULL BENEFITS	WHO CAN BE COVERED
Indemnity Medical	You and your dependents
Indemnity Prescription Drug	You and your dependents
Indemnity Dental	You and your dependents (if you reside in an area where an alternative dental plan is available, and you select it, that plan will provide your dental benefits)
Vision Care	You and your dependents
Life Coverage	You and your dependents
Accidental Death and Dismemberment Insurance	Employees only
Weekly Time Loss	Non-California employees only

Benefits Provided Through Health Maintenance Organization (HMO) Options

There are no HMO medical options for the Indemnity Plus Plan.

Alternate Dental Plans: Alternate dental plans are provided by:

- LIBERTY Dental Plan in California; and
- Kaiser Foundation Health Plan of Oregon in Oregon and Southwest Washington.

If you choose an alternate dental plan, your dental benefits will be described in a separate booklet provided by the alternate dental plan.

Enrollment: If you reside in an area where an alternate dental plan is available, you may choose between the optional coverage and the indemnity benefits described in this booklet at the time you begin participation with the Trust, during the annual open enrollment period or when an event giving rise to special enrollment rights occurs. If you elect an alternate dental plan, you must remain in that plan until the next open enrollment or a special enrollment event occurs. See additional details on page 3.

Eligibility – Indemnity Plus Plan

This section explains the eligibility and enrollment provisions for the Indemnity Plus Plan. Different eligibility rules can apply depending on the collective bargaining agreement under which you work.

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Enrollment

Participant Data Form: When an employer first makes contributions to the Trust on your behalf, you will be sent a Participant Data Form. In order for you and your dependents to receive benefits under the Trust and avoid delays in claims processing, you must complete and return this form to the Trust Administrative Office. *Failure to return the form, complete it in full, or submit supplemental documentation necessary to establish eligibility for you or your dependents may result in a delay in processing or a denial of your claims.* If you do not receive a Participant Data Form, call the Trust Administrative Office.

Updating Participant Data Form: Changes in marital status, the dependents covered, or in your address, must be reported to the Trust Administrative Office. See the Eligibility section for time limits on submitting this information. You may report these changes by submitting a revised Participant Data Form to the Trust Administrative Office. Additional information may be requested to establish dependent eligibility. Call the Trust Administrative Office for a Participant Data Form.

Eligibility

Eligible Employees: You are eligible for benefits under the Indemnity Plus Plan if you are an Employee of an employer which is party to a Teamsters collective bargaining agreement providing for participation in the Indemnity Plus Plan, you have the required number of compensable hours in a month, and the employer makes the required contributions on your behalf to the Trust.

Eligible Dependents:

Eligible dependents are your:

- Legally married spouse.
- Children under age 26 who are your:
 - Own children, natural or adopted;
 - Stepchildren or eligible foster children; or
 - Children for whom you are required to provide medical coverage under a Qualified Medical Child Support Order.
 - An unmarried eligible dependent child who is physically or mentally incapable of self-support at age 26 may continue under the plans while remaining incapacitated if your own coverage is in effect. To continue coverage, the child must be unmarried, financially dependent on you, and incapable of being employed.

To continue a child's health coverage as a disabled dependent, you must provide proof of the child's physical or mental incapacity prior to or within 31 days of when

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the child's coverage would otherwise terminate. The Trust may request additional proof as necessary to establish continued eligibility under these provisions.

Definitions Related to Dependent Eligibility:

Legally Married Spouse—To be eligible, your marriage must be legally recognized by the state in which you reside. As a result, domestic partners are not covered. Common-law spouses are not eligible unless the state in which you reside legally recognizes your common-law marriage.

Adopted Children—Legally adopted children include children placed in your home pending adoption. Placement for adoption means you assume a legal obligation for total or partial support of a child in anticipation of adopting the child.

Eligible Foster Children—A child placed with you by an authorized placement agency or by a judgment or order of a court of competent jurisdiction. A foster child does not include a child temporarily living in your home, a child placed in your home by a social service agency which retains control of the child, or a child whose natural parent is in a position to exercise or share in parental responsibility and control.

Stepchildren—A child of your legally married spouse.

Dual Coverage under the Trust: If your spouse is also eligible as an employee under the Trust, he or she will be eligible both as an employee and as a dependent. When both spouses are eligible employees, their children are eligible dependents of both. See the information about coordination of benefits beginning on page 78 of this Booklet.

Medical Child Support Orders: The Trust will observe the terms of Medical Child Support Orders that the Trust finds to be qualified under the applicable provisions of ERISA. Employees or dependents may submit Medical Child Support Orders to their Area Administrative Office for review. Call the Trust Administrative Office for additional information. Unless rescinded by the courts, a Qualified Medical Child Support order covers dependent children up to age 26.

Coverage Requirements

Coverage for all Plan benefits to which you and your eligible dependents are entitled begins at the same time, except as discussed in "When Coverage Begins for a New Dependent" and "Deferment of Life Coverage" below. Verification of incapacity will be requested at the time your coverage begins for children age 26 or older who you wish to cover under the Plan provisions dealing with physically or mentally incapacitated eligible dependent children.

When Coverage Begins: You become covered under the Indemnity Plus Plan for yourself and your eligible dependents on the first day of the second month following the initial month in which you have the required number of compensable hours for a participating employer who makes the required Plan contributions to the Trust. For example, you have the required

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number of compensable hours in January and the employer makes the required Plan contributions to the Trust in February; your coverage will begin on March 1 under the lag month provision requirements.

When Coverage Begins for a New Dependent: Children are eligible for all health benefits from birth, the time they are placed for adoption or are otherwise acquired. Life insurance coverage, however, does not take effect until children are 14 days old.

A newly acquired spouse is eligible from the date of your marriage provided that you timely notify the Trust Administrative Office.

Remember that an updated Participant Data Form must be submitted when you add a new dependent. If you need a Participant Data Form, call the Trust Administrative Office.

When Coverage Begins – Life Coverage: If you or an eligible dependent (except newborns) are confined in a hospital on the date life coverage would normally begin, coverage will be deferred until you or your dependent are released from the hospital. Life coverage for a dependent child does not begin until the child is 14 days old.

Continuation of Coverage Based on Employer Contributions: Once coverage begins, you and your eligible dependents will continue to have coverage for the second calendar month following the month in which you have the required number of compensable hours, provided your employer made the required contribution on your behalf for the hours you worked. For example, you have the required number of compensable hours in January and the employer makes the required Plan contribution to the Trust in February. Your coverage begins on March 1. If you work the required number of compensable hours in February, and the required contribution is made, you and your dependents will have coverage in April.

If you fail to receive the required number of hours of compensation to be eligible for coverage due to an on-the-job injury or an off-the-job injury or illness, your collective bargaining agreement may require your employer to continue to make contributions beyond the month you last earned eligibility. If your employer makes these contributions, the Trust will accept them and continue your coverage for the appropriate period. Contact the Trust Administrative Office for further information.

If you lose coverage due to a disabling condition, you must contact the Trust Administrative Office within 60 days of the onset of disability and complete the necessary forms to receive ongoing coverage through the Trust's Total Disability-Extension of Benefits. Disabling conditions must be certified by the treating physician.

Military Leave: The Trust will continue your coverage if you are involuntarily called to active duty status from the military reserves or national guard for military-related service, lasting 31 days or less. If your military service lasts more than 31 days, your coverage will end on the day you enter active military coverage. You will be eligible to continue your coverage through self-

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payment under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Continuation rights under USERRA are administered in accordance with the Trust's COBRA provisions.

If you qualify for reemployment under USERRA after you return from military service, your coverage under the Trust will be restored immediately.

Family and Medical Leave Act: Additionally, under the Family and Medical Leave Act (FMLA) your employer may be required to continue contributions on your behalf while you are on family or medical leave. If your employer makes these contributions, the Trust will accept them and continue your coverage for the appropriate period. Contact the Trust Administrative Office for further information.

Coverage During a Delinquency Through Self-Payments: If your coverage is interrupted due to an employer delinquency, you may continue coverage for yourself and your eligible dependents for up to six months by making self-payments at the regular employer contribution rate. Coverage under this section must be continuous. The Trust Administrative Office will notify you about the delinquency and payment due date. If the employer makes retroactive contributions directly, or as a result of a collection action by the Trustees, your self-payments will be refunded for any matching months.

When Your Coverage Ends: All benefits for you and your dependents will end when any of the following events occur:

- The last day of the preceding month for any month in which the eligibility requirements for the Indemnity Plus Plan are not met;
- The last day of the preceding month for any month in which the required employer contribution (or any applicable self-payment) is not made;
- The day the plan or the Trust terminates;
- The day of your death (and the last day of the last month of your earned coverage for your dependents);
- The day you are no longer eligible under an applicable collective bargaining agreement, or written special agreement, or are otherwise not eligible under the Trust's rules;
- The day your employer fails to pay the proper rate and your bargaining unit is terminated from participation in the Trust, as determined by the Trustees under the Trust's non-conforming rate policy; or
- The day you enter active military duty (except for certain defined situations during which your employer may be required to make contributions under some collective bargaining agreements or for periods of temporary active duty of less than 31 days).
- The last day of the month preceding the month for which any applicable self-payment is not made.

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When Your Dependents' Coverage Ends: All benefits for your dependents end on the day in which any of the following events occur:

- You, as the participant, lose your coverage;
- Your dependent fails to meet the plan's eligibility requirements for dependents;
- The last day of your last month of earned coverage following the date of your death; or
- Your dependent enters active military service (except for periods of temporary active duty of less than 31 days).
- The last day of the month preceding the month for which any applicable self-payment is not made.

Extension of Coverage—Special Rules

Possible Ways to Extend Coverage: Coverage for you and your dependents may be extended in certain situations. The provisions under which extended coverage is available and the plan options to which they apply are:

- COBRA Continuation Coverage;
- Total Disability—Extension of Medical, Dental, Prescription and Vision Benefits for You and Your Dependents;
- Total Disability—Extension of Medical Benefits Only for Individual's Disabling Condition Only;
- Total Disability—Extension of Life Insurance Coverage—(Employee Only);
- Extension of Coverage Based on Employer Contributions in Special Situations ; and
- Alternative Coverage through the Trust.

COBRA Continuation Coverage

COBRA is a federal law that requires certain group health plans to offer participants and their dependents the opportunity to extend their health coverage in specific situations when coverage under the plan would otherwise terminate. COBRA continuation coverage requires self-payments by you and your dependents and also requires that you notify the Trust in certain situations. Your rights and responsibilities under COBRA are explained below.

Self-Payments for Coverage (COBRA): Under the circumstances described below, you, your lawful spouse, and your eligible dependent children each have the independent right to elect to continue your Trust health coverage beyond the time coverage would ordinarily have ended pursuant to a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

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Notices to Trust Concerning COBRA: The Trust Administrative Office is responsible for administering COBRA continuation rights for you. All communications must:

- Be made in writing;
- Identify you and the eligible employee, if different; and
- Identify the Trust's name and be sent to the Trust Administrative Office.

The address of the Trust Administrative Office is listed on page 115 of this booklet.

Qualifying Events: You (as the participating employee) have the right to elect continuation of your health coverage from the Trust if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your spouse has the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The participating employee's termination of employment or reduction in hours of employment;
- Death of the participating employee;
- Divorce or legal separation of the participating employee; and
- The participating employee becoming eligible for Medicare.

A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:

- The participating employee's termination of employment or reduction in hours of employment;
- Death of the participating employee;
- Divorce or legal separation of the participating employee;
- The participating employee becoming eligible for Medicare; and
- The child no longer qualifying as an eligible dependent under the plan.

COBRA Notification Responsibilities: The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Trust of a loss of coverage resulting from a divorce, legal separation, or a child losing dependent status. **If you or your eligible dependents have a loss of coverage because of these events, you must notify the Trust Administrative Office at the address shown in the Plan Booklet within 60 days of the date of the above qualifying events.** Your written notice must identify the individual who has experienced the qualifying event, the eligible employee's name, the Trust's name, and the qualifying event which occurred. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the plan.

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Your employer is responsible for informing the Trust of any other qualifying event. The Board of Trustees, though, reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA: Once the Trust has received proper notice that a qualifying event has occurred, it will notify you and your eligible dependents of your rights to elect continuation coverage. A written election must be made within 60 days from the date coverage would otherwise end or 60 days from the date a COBRA notice is furnished by the Trust, if required and later. Unless otherwise stated on the election form, an election of COBRA coverage under the Trust by one family member covers all other eligible members of the same family. Your written election must be sent to the Trust Administrative Office. Failure to elect continuation coverage within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

Available Coverage: You and/or your eligible dependents may elect the following coverages:

- Medical and prescription drug only or medical, prescription drug, vision, and dental;

You may only continue coverage in the Plan option you had as of your qualifying event. If you elect COBRA continuation coverage, you may change coverage to or from an HMO option available through the Trust for which you are eligible during the Trust's annual open enrollment period.

COBRA continuation coverage is not available for time loss or life and accidental death and dismemberment benefits. If you elect to continue medical and prescription drug coverage only, you cannot add dental and vision coverage, nor can you switch to medical and prescription drug coverage only if you have elected to continue medical, prescription drug, dental, and vision coverage.

Adding New Dependents: COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. However, if you elect COBRA continuation coverage, and acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may add the new dependent to your COBRA coverage by providing written notice to the Trust within 60 days of acquiring the new dependent. The written notice must identify the employee, the new dependent, the Trust, the date the new dependent was acquired, and be mailed to the Trust Administrative Office. Children acquired through birth, adoption, or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs as discussed on page 14.

Continuous Coverage Required: Your coverage under COBRA must be continuous from the date your Trust coverage would have otherwise ended if COBRA continuation coverage was not elected.

Cost: A qualified beneficiary must pay the entire cost of the continuation coverage. The Trust uses a composite rate which means that you pay the same monthly rate if you are covering one

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person or an entire family. The cost for the coverage available through the Trust is set annually and depends on the option you choose. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the COBRA coverage options available to you. If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your or your dependent's disability.

Monthly Self-Payments Required: You or your eligible dependents are responsible for the full cost of COBRA continuation coverage. Self-payments for continuation of coverage are due on the first of each month for that month's coverage and must be sent to the Trust Administrative Office at the address shown on page 115 of this Plan Booklet. Coverage will be terminated if payment is not received by the Trust Office within 30 days of this due date. Checks that are received and do not clear the bank due to insufficient funds are considered non-payment. The only exception is that the self-payment for the period preceding the initial election of COBRA coverage may be made up to 45 days after the date of election. Your initial payment must cover all consecutive months for which you want coverage and be retroactive to when your Trust coverage ended. If your initial payment is not received or postmarked within 45 days of when you elected COBRA coverage, your right to COBRA continuation coverage will be lost.

Length of COBRA Continuation Coverage: Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours. For all other qualifying events (death of employee, divorce, or legal separation from employee, employee becoming Medicare eligible, or a child no longer qualifying as a dependent under the Plan) continuation coverage can last for up to 36 months. COBRA continuation coverage will end, however, on the last day of the monthly premium payment period if any one of the following occurs before the end of the maximum available continuation period:

- A required self-payment is not paid to the Trust Administrative Office on a timely basis for the next monthly coverage period;
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election;
- You or your eligible dependent provide written notice that you wish to terminate your coverage;
- You or your eligible dependent become entitled to Medicare benefits after the date of your COBRA election; or
- The date the Plan terminates or the date your employer no longer participates in the Plan unless your employer or its successor does not offer another health plan for any classification of its employees which formerly participated in the Trust.

Length of COBRA Continuation Coverage—Disabled Participants: If you have lost coverage because of a termination of employment or reduction of hours and you, your spouse, or any dependent covered by the Trust is determined by the Social Security Administration to be disabled by no later than the first 60 days of COBRA continuation coverage, your entire family

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can receive an additional 11 months of COBRA continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Trust Administrative Office in writing within 60 days of the latest of your qualifying event, the mailing of the COBRA notice, or receipt of your Social Security Disability Determination. Notice must also be provided to the Trust Administrative Office prior to the end of your initial 18-month period of COBRA continuation coverage. If the disabled individual extends coverage based on this provision and is subsequently found not to be disabled, you must notify the Trust Administrative Office in writing within 30 days of this determination.

Length of COBRA Continuation Coverage—Second Qualifying Event: Eligible dependents who are entitled to continuation coverage as the result of the employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 18 months of COBRA continuation coverage. Possible second qualifying events are the employee's death, a divorce or legal separation from the employee, a child losing dependent status, or the employee becoming eligible for Medicare during the initial 18 months of COBRA continuation coverage.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Trust Administrative Office in writing within 60 days of the second qualifying event. The written notice must identify the employee, the person continuing coverage, and the nature of the second qualifying event, and must be sent to the Trust Administrative Office. Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage extend beyond a total of 36 months.

Length of COBRA Continuation Coverage—Medicare Entitlement: If the employee has an 18-month qualifying event after becoming entitled to Medicare, dependents may continue coverage until the later of 18 months from the date coverage would otherwise end or 36 months from the date the employee became eligible for Medicare.

Additional Information: For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration or visit its website at www.dol.gov/ebsa.

To help ensure that you receive necessary notices, you should notify the Trust Administrative Office if your address or that of any family member changes. You should keep a copy of any written notices you send the Trust.

USERRA Military Service: If an individual has lost coverage because he or she has entered military service for longer than 31 days and is covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), the individual can elect to self-pay for coverage for up to a maximum of 24 months. USERRA rights under the Trust are governed by the same rules that apply to COBRA continuation coverage.

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Relationship Between COBRA and Medicare or Other Health Coverage: Your COBRA continuation coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. However, if you have Medicare or other group health coverage at the time you elect COBRA continuation coverage, you can be eligible for both.

If you have coverage under a Trust-sponsored Plan based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay primary and the Trust will coordinate with Medicare and pay secondary. Current employment status means you are still at work or have received short-term disability benefits for less than six months. If you have Medicare coverage based on end-stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute. If you have other group health coverage, it will pay primary and the Trust's continuation coverage will be secondary.

Coverage from Exchanges: Effective January 1, 2014, there are other coverage options for you and your family besides COBRA. You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Health Insurance Marketplace. If you actually enroll in COBRA continuation coverage, however, and drop it before the end of the maximum COBRA continuation period, it can affect your ability to enroll in a plan offered through the Health Insurance Marketplace outside the annual open enrollment period. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: Effective January 1, 2014, if you do not have health coverage, you may be subject an individual shared responsibility payment. Please contact www.healthcare.gov for more information regarding this requirement.

Total Disability – Extension of Benefits for You and Your Dependents

If you become totally disabled while eligible, all Plan benefits for you and your eligible dependents may be continued for up to six months. To receive continued coverage under this provision, you must be totally disabled, provide the Trust Administrative Office with a doctor's certification of your total disability in a form acceptable to the Trust and submit it within 60 days of the date your coverage would otherwise end. This provision is not available while on, or following the end of, COBRA coverage. If you are still totally disabled at the end of the three or six-month period, you may elect to continue coverage through the COBRA continuation provisions outlined above.

Benefits provided under this section will end if you cease being totally disabled or the Plan terminates.

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If you have returned to active employment after being on an Extension of Benefits under the Plan, you will be eligible for an Extension of Benefits in the following situation:

- For a new Total Disability unrelated to your previous Extension of Benefits, upon your return to active employment.
- If your Total Disability is the same as or related to your previous Extension of Benefits, you will be eligible after having worked sufficient hours for an employer contribution to be made. If your Total Disability is the same or related to your previous Extension of Benefits, the time spent on the previous Extension of Benefits will count against the six-month maximum available from the Plan.

Total Disability – Extension of Medical Benefits for Individual's Disabling Condition Only

If you or a covered dependent is totally disabled and under the care of a physician when your coverage terminates, you or your dependent may continue to receive medical benefits for covered services related to the illness or injury which caused the total disability. Under this provision, your total disability must prevent your performing any occupation. You must apply for this extended coverage no later than 60 days after your coverage would otherwise end.

Benefits under this provision will end if you cease being totally disabled, the Plan terminates, or you have been covered under this provision for 18 months. The Extension of Medical Benefits for Individual's Disabling Condition may be selected as an alternative to COBRA continuation coverage or, if you elect COBRA after COBRA continuation coverage ends or terminates.

When this extension applies, it will operate only to the extent that coverage for medical care is not otherwise provided for the person through the Trust.

Total Disability – Extension of Life Insurance Coverage (Employees)

If you become totally disabled before you reach age 60, your term life insurance may be continued by the Trust as long as you remain totally disabled. You must submit written proof of your total disability to the Trust's life insurance carrier no later than one year after the date you become disabled. You will be required to periodically submit proof of your continuing disability but not more than once each year. This provision will end under certain conditions. In no event will it continue past attainment of age 65.

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Extension of Coverage Based on Employer Contributions in Special Situations

If you would otherwise lose coverage because you have failed to work the required number of hours, your employer may be required to make contributions to the Trust on your behalf in special situations. Contact the Trust Administrative Office if you have questions.

Alternative Coverage Through The Trust

The Trust's self-funded medical, prescription drug, dental, and vision programs offer no conversion option.

If you cease active employment and retire, you and your dependents may be eligible for benefits under the Trust's Retirees Health and Welfare Plan ("Retiree Plan"). Eligibility and benefits under the Retiree Plan are explained in a separate booklet available from the Trust Office. **Your application to participate in the Retiree Plan must be submitted no later than 90 days following the later of your Western Conference of Teamsters pension effective date or the end of your WTWT Plan coverage. Please be aware that this application must be submitted to the Trust Office for this Trust and is separate from your pension application.**

Finally, if you have lost coverage because your employer has failed to make the required contributions, the Trust will not provide COBRA continuation coverage but will allow you to pay the employer contribution rate for up to six months.

Conversion of Term Life Insurance: You may be able to convert your term life Insurance to one of a number of individual policies. See "Changing to an Individual Policy" on page 67.

Your Retirement and Possible Eligibility Under the WTWT Retiree Plan

If you retire from active employment and begin receiving your Western Conference of Teamsters Pension benefit or another Teamster pension benefit, you and your dependents may be eligible for benefits under the Retiree Plan. Eligibility and benefits under the Retiree Plan are explained in a separate Retiree Plan booklet. To assist you in planning for your retirement, the following outline of the Retiree Plan's current eligibility rules is provided.

Not all employers participating in the Trust make the contributions required to be eligible for retiree coverage. If you have questions concerning whether your employer makes contributions for Retiree Plan coverage please contact the Trust Administrative Office.

Application for Retiree Plan Coverage – 90-Day Rule: Your Teamster pension benefit does not include retiree health coverage. To receive Retiree Plan coverage from the Trust, you must apply separately. To assure that your Retiree Plan application is handled in a timely manner, it

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should be submitted to the Trust Administrative Office prior to your contemplated retirement date. In any event, your Retiree Plan application must be submitted to the Trust Administrative Office no more than 90 days after the latest of:

- Your Western Conference of Teamsters pension effective date;
- Your pension effective date under another pension plan contained in a Teamster bargaining agreement, or
- The end of your WTWT Plan coverage.

An application submitted more than 90 days after the latest of the events listed above, will not be accepted and you and your dependents will not be eligible for Retiree Plan coverage.

In addition to this timely application requirement, your active coverage under the WTWT and your Retiree Plan coverage must be continuous unless you qualify for one of the following exceptions (which are discussed in more detail in the Retiree Plan Booklet):

- You qualify for a postponement or suspension of Retiree Plan coverage based on other medical benefits being available;
- You irrevocably and timely elect to defer your Retiree Plan coverage until you are Medicare eligible; or
- You have submitted an application to the Western Conference of Teamsters Pension Plan and you elect to defer your Retiree Plan coverage until your pension application is approved. If you make this election your Retiree Plan coverage will not start until the first of the month following the month in which your pension application is approved.

To utilize any of these postponement-of-coverage options, you must still apply for Retiree Plan coverage in the time period referenced above.

Eligibility under the Retiree Plan requires:

- 1. Retirement after employment with an employer contributing to the Trust's retiree plan:** You have been actively employed with an employer who contributed on your behalf to the Trust's retiree plan.
- 2. No other group coverage:** You are not eligible as an Employee under any group health care or service-type plan of benefits.
- 3. Must be age 55 or older unless qualified for "PEER" pension:** You are at least 55 years of age, or if younger than 55, you qualified for retirement under the "PEER" retirement formula as provided by the Western Conference of Teamsters Pension Trust, or under a comparable formula from any other Teamsters Pension Trust.

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4. **Must be receiving a Teamster pension:** You have retired under the Western Conference of Teamsters Pension Trust, or any other Teamster Pension Trust, and are receiving a monthly retirement benefit from that Trust. If you are not receiving a monthly retirement benefit because your employer has not made pension contributions to the Pension Trust, you may still be eligible if you meet all of the other eligibility requirements and your employer has been a contributing employer to this Trust continuously for at least ten years.
5. **Must have earned 60 months of Trust contributions within prior 84 months (60/84 Rule):** You have been covered by this Trust under a collective bargaining agreement accepted by the Trust and have earned 60 months of Trust contributions within the 84 months immediately preceding your pension effective date (Western Conference of Teamsters Pension Trust or any other Teamsters Pension Trust). The requirement for 60 months of Trust contributions is referred to as the “required months of Trust contributions.” The requirement that the Trust contributions be earned in an 84-month time frame immediately preceding your pension effective date is referred to as the “qualifying period.”

Alternative Eligibility Test— Long-Term Career Employees: If you fail to qualify under the 60/84 rule you may, be eligible if: (a) you have earned 36 months of Trust employer contributions within the 84 months immediately preceding your pension effective date; and (b) your overall employment history includes a cumulative total of 180 months, or more, of Trust contributions (or Trust contributions combined with contributions to another IBT health and welfare trust which covers the same work classifications as this Trust) within the 300 months immediately preceding your pension effective date.

Information concerning the number of months of Trust contributions that have been made on your behalf during the qualifying period is available from the Trust Administrative Office. In determining whether you have had the required months of Trust contributions, the following months may, if necessary, be included:

- If your employer has been delinquent in making Trust contributions, one month of credit will be given for each month of delinquency, up to a total of 12 months;
- If you have been disabled and unable to work, one month of credit will be given for each month of disability, up to a total of 12 months;
- If you have received benefit eligibility under the Casual Plan under a WTWT collective bargaining agreement, one month of credit will be given for each month of such coverage up to a total of six months;
- If you have received benefit eligibility under the Catastrophic Needs Medical Plan under a WTWT collective bargaining agreement, one month of credit will be given for each month of such coverage up to a total of six months; and
- If you have made COBRA continuation coverage self-payments, one month of credit will be given for each month of continuation coverage, up to a total of six months.

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Note: If you leave active employment because of disability and have applied for a disability retirement from the Western Conference of Teamsters Pension Trust, or any other Teamsters Pension Trust, and if your disability retirement effective date is extended because of a delay in obtaining a related Social Security award, the 84-month qualifying period will be extended by one month for each month of delay but not to exceed 12 additional months.

- 6. Must make required self-payments:** You must agree to make monthly Retiree Plan self-payments for yourself, and for your spouse for whom coverage is desired, in an amount determined by the Board of Trustees. To continue eligibility, these payments must be made in a timely manner. The Board of Trustees has the right to change the self-payment rates from time to time.

Please make note that if your last employer ceases to participate in the Trust (i.e., becomes a withdrawn employer); you and your spouse will be charged a self-payment rate which reflects the “full cost” of the Retiree Plan benefit.

Options Available for Retirees

In addition to immediate enrollment in the Retiree Plan, you or your spouse has the following additional options:

Postponement or Suspension of Coverage When Other Benefits Are Available: You or your spouse can suspend or postpone your Retiree Plan coverage if you have other employment-related health coverage. If you have met the Retiree Plan eligibility rules and wish to suspend your Retiree Plan coverage, contact the Trust Administrative Office for the necessary form. If you qualify, no self-payments will be required while your coverage is suspended. No benefits will be provided by the Retiree Plan while you have suspended Trust coverage due to other group health coverage.

When you lose your other coverage, contact the Trust Administrative Office within 30 days to resume your Retiree Plan coverage. The Trust Administrative Office will require documentation that your other group health coverage has been continuous and has not terminated from the date you requested a suspension until the date you request Retiree Plan coverage to resume. It will advise you of your monthly self-payment amount. When the documentation and self-payment is received, your Retiree Plan coverage will begin or resume.

Deferral of Coverage Until Medicare Eligible: If you or your spouse became eligible to participate in the Retiree Plan on or after September 1, 2002, you can make a one-time election that defers Retiree Plan participation until you are Medicare eligible. Under this option, there is no requirement that you or your spouse have other health coverage while you are not participating in the Retiree Plan. Once this deferral election is made, your choice is irrevocable, and you cannot resume participation in the Retiree Plan until you are Medicare eligible. To select this option, you must submit a deferral request to the Trust Administrative Office within

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the same 90-day period you have for electing to initially participate in the Retiree Plan. You must then notify the Trust Administrative Office within 30 days of your becoming Medicare eligible to receive Retiree Plan coverage.

Retiree Benefits Not Guaranteed

Retiree Plan Benefits Not Guaranteed: Benefits under the Retiree Plan are not guaranteed. Benefits are provided on a month-to-month basis, and are financed from a portion of the employer contributions paid for Employees and from retiree and dependent self-payments. The Board of Trustees reserves the right to modify or terminate the Retiree Plan and the Retiree Pre-Funding Program as the circumstances may warrant.

Retiree Plan Booklets Available from the Trust Administrative Offices: For a copy of the Retiree Plan booklet, or information about the Retiree Plan, contact the Trust Administrative Office.



Indemnity Medical Benefits

This section explains the indemnity medical benefits under the Indemnity Plus Plan.

INDEMNITY MEDICAL BENEFITS

Indemnity Plus Plan Benefits Summary

There are no HMO options for the Indemnity Plus Plan. The benefits available are summarized below.

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
MAJOR PLAN FEATURES		
Calendar Year Deductible (*waived for accidental injury for eligible expenses incurred within 90 days from the date of the accident, hospice and home healthcare)	No deductible	\$1,500 per person; \$3,000 per family (does not include amounts in excess of usual, customary, and reasonable (UCR) or non-covered services)
Calendar Year Out-of-Pocket Maximum (does not include deductibles)	No maximum	\$4,500 per person; \$9,000 per family (does not include amounts in excess of usual, customary, and Reasonable (UCR) or non-covered services)
Coinsurance	No co-insurance	50% after deductible met
How the Plan Works	Eligible expenses provided by PPO Providers are paid at 100% of the network allowed amounts subject to co-pays for certain services	Eligible expenses provided by non-PPO Providers are paid at 50% of Usual, Customary and Reasonable (UCR) after the plan's calendar year deductible until your out-of-pocket expenses (your 50% cost share) for coinsurance adds up to \$4,500 per person or \$9,000 per family during a calendar year. Then the Plan pays 100% of most <i>eligible</i> expenses for the rest of the calendar year up.

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
HOSPITAL AND EMERGENCY ROOM BENEFITS		
Emergency Room Care	You pay \$75 co-pay per visit, then the Plan pays 100% of the PPO allowed amount. Co-pay waived for treatment	You pay \$75 co-pay per visit, and then the Plan pays 50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar

INDEMNITY MEDICAL BENEFITS

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
	of injury within 48 hours of covered accident or if admitted.	year deductible if due to an illness. Co-pay waived for treatment of injury within 48 hours of covered accident or if admitted.
Urgent Care	\$35 co-pay	50% of usual, customary and reasonable (UCR) after satisfaction of Calendar year deductible
Inpatient Hospital	\$250 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Utilization Review Required for Hospitalization	If the admission is not pre-authorized the coinsurance will be reduced by 10%.	If the admission is not pre-authorized benefits are subject to Usual, Customary and Reasonable (UCR) and the inpatient hospital coinsurance will be reduced by 10%.
PHYSICIAN SERVICES		
Office Visit	\$ 15 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Inpatient Hospital	\$0 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Outpatient Hospital	\$0 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Surgery	\$0 co-pay for surgeon \$250 co-pay for facility	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Preventive Care (routine outpatient physical exams, immunizations, and well-child care)	\$15 co-pay covered	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Inpatient Well Newborn Care	\$0 co-pay for up to seven days following birth	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible for up to seven days following birth

INDEMNITY MEDICAL BENEFITS

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
ALTERNATIVE TREATMENT SETTINGS, INSTEAD OF HOSPITALIZATION		
Home Health Care	\$0 co-pay Up to 60 visits per person per calendar year.	50% of usual, customary, and reasonable (UCR); up to 60 visits per person per calendar year. The calendar year deductible is waived for this service.
Hospice	\$0 co-pay up to \$5,000 for one period of care.	50% of usual, customary, and reasonable (UCR); up to \$5,000 for one period of care. The calendar year deductible is waived for this service.
Skilled Nursing Facility	\$250 co-pay up to 60 days per calendar year	50% of usual, customary, and reasonable (UCR) charges after satisfaction of the calendar year deductible; up to 60 days per calendar year.
OTHER PLAN BENEFITS		
Diagnostic X-ray and Lab In or Outpatient	\$0 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible. Effective September 1, 2018, Non-PPO laboratory claims limited to \$300 per date of service.
Durable Medical Equipment	\$0 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible
Physical Therapy (must be a physician referral), Occupational Therapy (must be a physician referral) and spinal manipulations (performed by a D.O. or D.C.)	\$15 co-pay Up to 20 treatments for each type of service per calendar year (combined PPO/ Non-PPO maximum)	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible; up to 20 treatments per calendar year (combined PPO / Non-PPO maximum)
Acupuncture	\$15 co-pay Up to 10 treatments per calendar year (combined PPO / Non-PPO maximum)	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible; up to 10 treatments per calendar year (combined PPO / Non-PPO maximum)
Ambulance – Must be Medically necessary transportation and not for Patient/Family Convenience	\$0 co-pay	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible

INDEMNITY MEDICAL BENEFITS

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
Massage Therapy (must be a physician referral)	\$15 co-pay Up to 10 treatments per calendar year (combined PPO / Non-PPO maximum)	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible; up to 10 treatments per calendar year (combined PPO / Non-PPO maximum)
Jaw Treatment Benefit	\$0 co-pay up to a \$6,000 lifetime maximum combined PPO/Non-PPO for TMJ or MPD. Regular benefits apply to other jaw conditions and accidental injuries.	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible; up to a \$6,000 lifetime maximum combined PPO/Non-PPO for TMJ or MPD. Regular benefits apply to other jaw conditions and accidental injuries.
Hearing Aids	\$15 co-pay for hearing exam up to \$500 per ear, (\$1,000 maximum) combined PPO / Non-PPO. Replacement once in a three-year period.	50% of usual, customary, and reasonable (UCR) after satisfaction of the calendar year deductible; up to \$500 per ear, (\$1,000 maximum) combined PPO / Non-PPO. Replacement once in a three-year period.
Speech Therapy	\$15 co-pay; up to 20 treatments per calendar year PPO / Non-PPO	50% of usual, customary, and reasonable (UCR) after satisfaction if the calendar year deductible; up to 20 treatments per calendar year combined PPO / Non-PPO

The description of your prescription drug benefits begins on page 46.

Calendar Year Deductible

There is no deductible if you use an in-network PPO Provider. If you use a non-PPO Provider the annual deductible is \$1,500 per person of eligible expenses (\$3,000 of eligible expenses per family). To satisfy your deductible, eligible expenses submitted to the Trust Administrative Office will be applied until the annual amount has been reached.

Deductible Carryover Provision: The calendar year deductible must be satisfied by eligible expenses incurred in that year. Any eligible expenses incurred during the last three months of the previous calendar year and applied to that year's deductible, will be carried over and also applied to the next year's deductible. This carryover provision does not apply to out-of-pocket expenses.

INDEMNITY MEDICAL BENEFITS

Accidental Injury: The deductible will not apply to eligible expenses due to an accidental injury which are incurred within 90 days of the accident.

Coinsurance

If you use a preferred provider, there is no co-insurance. There are however, co-pays for various types of services such as out-patient office visits, facility fees, emergency and urgent care, rehabilitative care and other services. If you use a non-PPO Provider, the Medical Plan will pay 50% of the usual, customary, and reasonable (UCR) fees for eligible expenses after the deductible is met.

Annual Out-of-Pocket Maximum for Coinsurance

There is no annual out-of-pocket maximum for services and supplies received from a PPO Provider.

Eligible expenses provided by non-PPO Providers are paid at 50% until your out-of-pocket expenses (your 50% cost share) for coinsurance adds up to \$4,500 per person or \$9,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year. Eligible out-of-pocket expenses do not include deductibles, co-payments, reductions for not preauthorizing, amounts in excess of usual, customary, and reasonable (UCR) charges as well as expenses not eligible for reimbursement under the Plan.

Any additional coinsurance requirements for non-compliance with inpatient hospital preauthorization requirements for either PPO or non-PPO Providers do not apply to the out-of-pocket expense maximum.

Hidden Providers/Emergency Services: In limited circumstances benefits for services provided by a non-PPO Provider will be reimbursed at the PPO Provider rate. However, submitted expenses are still subject to Usual, Customary and Reasonable (UCR) requirement. These circumstances are:

- Eligible expenses by non-PPO providers for life threatening emergencies and/or life threatening accidental injuries are paid as if provided by a PPO Provider;
- When you use a PPO facility and receive services from a non-PPO anesthesiologist, radiologist, emergency room physician, pathologist or laboratory, or in an emergency situation receive services from non-PPO staff or on-call physicians; and
- You receive services from a PPO physician who in turn utilizes services from a non-PPO co-surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, or laboratory.

If benefits are paid at the PPO rate to a non-PPO Provider under these provisions, the amount is counted toward the annual out-of-pocket maximum for PPO Providers.

INDEMNITY MEDICAL BENEFITS

Out of Area Benefits: If you receive care from a non-PPO Provider, the Plan pays most eligible expenses at 50% of the usual, customary, and reasonable (UCR) allowance. If you live over 30 miles from the nearest network provider or network facility that provides the medically necessary services you require, eligible expenses will be paid at 80% of usual, customary, and reasonable (UCR). Any charges in excess of the usual, customary, and reasonable (UCR) allowance are your responsibility.

Eligible Expenses

You and your eligible dependents are entitled to benefit payments for the medical services and supplies described below, if medically necessary for the treatment of sickness or injury and if ordered by a physician. Benefit payments are subject to all other Plan provisions including those relating to PPO Providers, care management, definitions, and exclusions.

Inpatient Hospital Expenses:

Hospital Charges for Room and Board—For PPO Provider benefits are paid at 100% subject to a \$250 co-pay. For non-PPO Provider benefits are paid at 50% of UCR after the deductible is satisfied.

Hospital Charges for Private Room—If necessary for isolation due to the patient's communicable disease.

Other Hospital Services—Charges for other services and supplies furnished by the hospital such as operating room, medicines, drugs, anesthesia, x-ray examinations, treatment with radiation and other radioactive substances, laboratory tests, surgical dressings and supplies, but not professional services.

Covered Expenses In or Out of the Hospital:

Acupuncture—Treatment by a licensed or registered acupuncturist. The Plan covers charges for medically necessary services to a maximum of 10 combined PPO/Non-PPO visits per calendar year. Services at a PPO Provider are subject to a \$15 co-pay. Non-PPO services are covered at 50% of UCR after the annual deductible is satisfied.

Ambulance—Local professional licensed ambulance service, when medically necessary, to or from the nearest accredited hospital qualified to treat the condition. Air ambulance services are covered when medically necessary and only when other ambulance transportation would endanger life or safety. PPO ambulance services will be paid at 100%. Non-PPO ambulance services will be paid at the preferred level subject to the Plan's usual, customary, and reasonable determination.

Ambulatory Surgical Centers—The PPO Providers are paid at 100% and subject to a \$250 co-pay. The Trust will pay a usual and customary and reasonable rate subject to a \$1,000 daily benefit limit on facility charges of Non-PPO ambulatory surgical centers.

INDEMNITY MEDICAL BENEFITS

Anesthesia—Cost of anesthetics and their administration for treatment of a covered medical condition.

Bariatric Surgery—Bariatric surgery that is medically necessary and meets criteria established by the Trust or its medical review organization is covered. To receive benefits, the bariatric surgery must be received at a Blue Center of Distinction. See page 30 for additional information.

Blood transfusions—Including cost of blood and blood derivatives used by a covered patient and not replaced by a donor.

Chemical Dependency—Benefits for the treatment of chemical dependency are provided under the same terms as other medical benefits. All inpatient admissions and residential treatment programs must be pre-authorized.

Dental Services—Charges for treatment by a doctor, dentist, or dental surgeon for removal of a malignant tumor or treatment of injuries to natural teeth (including replacement of such teeth and related x-rays) within 12 months after the accident. Coverage for care in an emergency room, hospital, or surgery center is not covered. Charges made for the treatment of deteriorating teeth and gums due to radiation therapy or chemotherapy is covered, as long as such treatment is considered medically necessary. Such coverage is limited to a \$10,000 lifetime maximum.

Dietary Formula—When medically necessary for the treatment of phenylketonuria (PKU).

Doctors Services—Covered surgery, home, office, or hospital visits and other medical care.

Durable Medical Equipment and Medical Supplies—Covered for artificial limbs, eyes, and larynx; surgical dressings; casts, splints, trusses, braces, crutches, and blood glucose monitors; rental of wheel chair, hospital bed, and respirator; and oxygen and rental of equipment for its administration. The rental cost of durable medical equipment is covered up to the purchase price.

Hearing Aids—Charges for a hearing examination and hearing aid devices up to \$500 per ear with a maximum of \$1,000 combined PPO/Non-PPO in any three-year period. You must be examined by a licensed physician or a licensed or certified audiologist. The examining physician must certify that the patient is suffering from hearing loss that may be lessened by use of the hearing aid.

Inpatient Well-Baby Care—Eligible inpatient hospital expenses for well newborns from birth up to seven days. For the child's charges to be covered, the mother must also be hospitalized.

INDEMNITY MEDICAL BENEFITS

Jaw Treatment—Diagnosis and treatment, surgical and non-surgical, by a physician or dentist for Temporomandibular Joint (TMJ)/Myofascial Pain Dysfunction (MPD) and conditions which the Trust, upon medical review, determines are related to such jaw conditions, will be covered up to a \$6,000 lifetime maximum combined PPO/Non-PPO. Regular Plan benefits apply to other jaw conditions, including treatment related to congenital skeletal deformities, tumors, or malignancies.

Jaw treatment maximums do not apply to jaw surgery or repair if the required treatment is for accidental injury. Regular Plan benefits apply and require treatment to be started within the 12 months immediately following the accident unless you can show that it was not reasonably possible to begin treatment within the 12 months and treatment began as soon as reasonably possible. Orthodontia is not covered under this benefit.

Laboratory Charges — The Plan has a \$300 per date of service limit on services provided by a non-PPO laboratory. Normal plan benefits apply to charges by a PPO laboratory.

Massage Therapy—Services rendered by a licensed, certified, or registered massage therapist. The Plan covers charges for medically necessary services to a maximum of 10 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

Mastectomy Benefits—Reconstruction of the breast after mastectomy, treatment of complications in all stages of mastectomy including lymphedemas, any prostheses required as a result of the mastectomy, and surgery and reconstruction on the non-diseased breast to make it equal in size with the reconstructed diseased breast.

Maternity Care—Effective September 1, 2017, maternity benefits for dependent children are provided on the same basis as for employees and spouse.

Mental Health—Benefits for the treatment of mental health will be provided on the same basis as other medical benefits. All inpatient and residential admissions need to be preauthorized.

Nursing Care—Private duty nursing by a registered nurse.

Obstetrical Care—Hospital and Professional—Pregnancy and childbirth are covered as any other condition for you, your spouse, or eligible dependent child (effective as of September 1, 2017).

Occupational Therapy, Physical Therapy and Spinal Manipulation—Services rendered by appropriately licensed PPO Provider are paid at 100% subject to a \$15 co-pay. There must be a physician referral and are limited to 20 treatments each per calendar year.

Organ and Bone Marrow Transplants—Human organ transplants considered medically necessary, appropriate, and effective using prevailing standards of community medical

INDEMNITY MEDICAL BENEFITS

practice. A Blue Center of Distinction must be used for benefits to be payable. For additional detail, see page 30.

Experimental or investigational transplants are not covered.

Medical expenses of the donor will be covered in absence of other group insurance. These expenses include testing for potential donors, and selecting and procuring the organ. If donor expenses are eligible under another plan, this Plan's coordination of benefits provision will apply.

- **Donor Costs**

Covered services include: selection, removal (harvesting), and evaluation of the donor organ, bone marrow, or stem cells; transportation of donor organ, bone marrow, and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and, storage costs for bone marrow and stem cells for a period of up to 12 months.

- **Transportation, Meals, and Lodging Expenses Actually Incurred**

Reasonable and necessary expenses for travel, lodging, and meals for the transplant recipient (while not confined) and/or donor and one companion will be covered subject to the following limitations:

- The transplant recipient and/or donor must reside more than 50 miles from the approved transplant center;
- The travel must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- When the recipient and/or donor is not a dependent minor child, transportation, covered lodging, and meal expenses for the recipient and/or donor and one companion will be reimbursed (receipts must be provided to the Trust);
- When the recipient and/or donor is a dependent child, transportation, covered lodging, and meal expenses for the recipient and/or donor and two companions will be reimbursed (receipts must be provided to the Trust); and
- Covered transportation, lodging, and meal expenses incurred by the transplant recipient and/or donor and companion(s) are limited to \$7,500 each per transplant.

These expenses must be reasonable for the services they relate to and require preauthorization from the Trust's utilization review program.

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- **No transplant benefits Will Be Paid for:**

- Non-human, artificial, or mechanical transplants;
- Recipients not covered under the Plan;
- Experimental or investigational procedures as determined by the Plan; or
- Donor and procurement costs incurred outside the United States unless pre-authorized by the Plan.

Orthotics – Impression casting, corrective shoes, and appliances are covered once every 24 months when medically necessary and prescribed by your attending physician. Orthotics prescribed for sports or recreational purposes are not covered.

Pervasive Development Disorder or Autism – This Plan provides coverage for behavioral health treatment for Pervasive Developmental Disorder or Autism. Pre-service review for all behavioral health treatment services for Pervasive Development Disorder or Autism is required in order for these services to be covered by this plan. Treatment must be prescribed by a licensed physician. (an MD or DO or developed by a licensed clinical psychologist). The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider. The treatment plan is not used for purposes of providing or reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. If you have questions about who is a Qualified Autism Service Professional contact the Trust Administrative Office.

Physical Therapy – See Occupational Therapy services on page 27.

Prostheses – Prostheses including artificial limbs, eyes, and larynx to replace natural body parts. Cosmetic or electronic prostheses are not covered. Prostheses will be replaced only if the original cannot be made functional.

Radiation and Chemotherapy Treatments – Includes treatment with radioactive substances.

Routine Mammography – Diagnostic and screening mammography recommended by your physician.

Routine Physical Exams – Routine physical exams, related lab work and x-rays, well-child care, and immunizations, \$15 co-pay for PPO Providers.

Spinal Manipulations – See Occupational Therapy benefits on page 27.

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Speech Therapy—If part of a prescribed treatment program, speech therapy by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by injury or sickness (except a mental, psychoneurotic, or personality disorder) or by surgery for that injury or sickness is covered up to 20 treatments per calendar year combined PPO/Non-PPO. Oral motor training is not covered. \$15 per treatment co-pay for PPO Provider. Preauthorization is recommended.

Vision Therapy—Medically necessary vision therapy for treatment of the following conditions:

- Amblyopia (with orthoptics and occlusion therapy)
- Acquired esotropia prior to surgical intervention (with prism adaptation)
- Convergence insufficiency and intermittent exotropia (with convergence training)

Because vision therapy programs are individualized, the number of visits per week and the total number of visits varies depending upon the nature and severity of the problem being treated and the needs of the individual receiving treatment. Generally, maximum improvement will require no more than 24 treatments (one to two times weekly for 4-6 months) and may be achieved more quickly. Requests for additional visits will be considered on a case-by-case basis.

Care Management and Special Benefit Programs

The Trust provides Care Management Programs to help you receive cost effective care and help the Trust control costs to ensure appropriate use of Trust resources. These programs apply to all Employees and their dependents which are covered by the Trust's indemnity medical benefits. Your care management programs described on the following pages include:

- Preferred Provider Organization (PPO);
- Hospital Preauthorization (Mandatory);
- Centers of Distinction for bariatric surgery and transplants
- Other Programs:
 - Hospital Discharge Planning and Case Management;
 - Maternity Options Management (MOM) Program;
 - Skilled Nursing Facility;
 - Home Health Care; and
 - Hospice Care.

Preferred Provider Organization (PPO): A Preferred Provider Organization (PPO) is available to most Trust participants and their covered dependents. The PPO helps the Trust offer health

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care at a lower cost. The PPO credentials and contracts with preferred providers offer a network of primary care physicians, specialists, hospitals, and clinics. The PPO also negotiates fees with these doctors and facilities and passes the savings on to you, so that you can obtain medical services from these providers at a favorable rate. Of course, you are not required to use PPO Providers. You can use any eligible provider you wish.

When you use a PPO Provider, your out-of-pocket expenses will be less than if you were treated by a non-PPO Provider since you have a higher level of benefits and your benefits are based on discounted rates. You will be responsible for any co-payment. The PPO will also handle your claim paperwork.

If you elect to use a non-PPO Provider, the Trust will pay a percentage of usual, customary, and reasonable (UCR) charges in excess of the deductible. In addition to your deductible and coinsurance, you will be responsible for any amount over usual, customary, and reasonable (UCR).

PPO Directories: For the most up-to-date information, you can check online at www.anthem.com/ca if you reside in California. If you live outside California, go to www.bluecares.com. Once you find this page, go to the "Blue Finder" tab, then click on "Doctor Finder." You will then enter your information to find a network provider near you. Because PPO Providers change, be sure to verify your provider's participation before obtaining services; being listed in the PPO directory does not guarantee the provider continues to participate in the PPO.

Hospital Preauthorization (Mandatory): All non-emergency admission to hospitals, including inpatient and residential admissions for the treatment of mental health and chemical dependency must be pre-authorized. Additionally, all bariatric surgery and organ transplants must be preauthorized. The phone number to call for preauthorization is listed on the back of the member's I.D. card (1-800-274-7767). Each hospital admission is reviewed by the Utilization Review Company before the patient enters the hospital. If your hospital or inpatient stay is not pre-certified, benefits are paid at a reduced rate, as follows:

Failure to preauthorize inpatient admissions will result in a reduction in your benefits.

- PPO hospital charges are paid at a 10% coinsurance reduction
- Non-PPO hospital charges are paid at a 10% coinsurance reduction after satisfaction of the calendar year deductible if admission is not pre-certified.

If you fail to pre-certify bariatric surgery or an organ transplant no benefits will be paid.

If the admission is an emergency, you or your provider must notify the Utilization Review Company within 48 hours after admission.

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Admissions for childbirth without preauthorization are allowed for up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. The discharge may be earlier as long as the patient and provider agree.

Centers of Distinction: To receive benefits, the Trust requires that bariatric surgery and transplants be performed in specified facilities referred to as Blue Centers of Distinction.

Other Programs:

Hospital Discharge Planning: Discharge planning helps in situations when you require continued medical care, but not necessarily inpatient hospitalization. The Utilization Review Company employs case management nurses who will work with you, your family, your physician, and the hospital staff to develop a plan that follows your release from the hospital. Your case manager also can arrange home health care, skilled nursing care, and hospice care.

Skilled Nursing Facility: The Plan covers skilled nursing facility care after you or a covered dependent have been hospitalized and have received benefits for at least three days. The care must be recommended by your doctor for the same condition which caused your hospitalization. Charges for custodial care, personal items, and private duty nursing are excluded. Benefits are payable for board and other services and supplies furnished by the facility for medically necessary care. The patient must be under continuous care of his or her doctor and require 24-hour nursing care.

Covered charges for the same or related conditions are covered up to a 60 day per calendar year maximum, combined PPO/Non-PPO.

Home Health Care: The Trust pays for eligible expenses provided as part of a home health care treatment plan to treat an illness or injury. Home health care benefits pay 100% of eligible expenses for services and supplies provided by a Home Health Care Agency, subject to the following conditions:

- The patient is under the care of a doctor who submits a written “home health care plan” for care and treatment in the patient’s home; and
- Services and supplies are furnished when, if it was not for home health care, inpatient confinement in a hospital, convalescent nursing home, or skilled nursing facility would be required.

The eligible expenses are the Home Health Care Agency’s charges for the following services and supplies ordered by the doctor under the home health care plan and furnished in the patient’s home:

- Part-time or intermittent nursing provided or supervised by a Registered Nurse (R.N.);

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- Part-time or intermittent home health aide services, primarily for the patient's care;
- Physical, occupational, speech, or respiratory therapy by a qualified therapist;
- Nutrition counseling provided by or under the supervision of a registered dietitian; and
- Medical supplies, laboratory services, drugs, and medications prescribed by a doctor.

The Trust pays for up to 60 home health care visits per person, in a calendar year PPO/Non-PPO combined. A visit by a representative of a home health care agency, other than a home health aide, constitutes one visit. For home health aides, each visit lasting four hours or less counts as one visit. If a visit exceeds four hours, each four hours or fraction of an hour counts as a separate visit.

The annual plan deductible is waived for home health care benefits. Coverage for Non-PPO Providers is limited to usual, customary, and reasonable (UCR) charges.

Hospice Care: The Trust covers charges incurred by a terminally ill person in a hospice care program. Certification of terminal illness must be provided to the Area Administrative Office.

Benefits are paid if the hospice service or stay is:

- Provided while the terminally ill person is an eligible individual;
- Ordered by the attending physician as part of the hospice care program;
- Charged by the hospice care program; and
- Provided within six months of the terminally ill person's entry or re-entry (after a remission period) in the hospice care program.

The lifetime maximum for hospice services for one period of care is \$5,000 per person PPO and Non-PPO combined. The annual plan deductible is waived for Hospice Care benefits. Coverage for Non-PPO Providers is limited to usual, customary, and reasonable (UCR) charges.

Hospice Care Bereavement Benefits—As part of Hospice Care, the Trust covers counseling services for the family of a terminally ill person, if ordered and received under the hospice care program.

Bereavement benefits for a Trust participant and his or her covered dependents will be paid if:

- The terminally ill person was in the hospice care program on the day prior to death;
- Requested by a covered family member;

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- The charges are incurred within three months following the date the terminally ill person dies;
- Counseling is ordered and received through the hospice care program.

The maximum lifetime bereavement benefit per family is \$200, PPO and Non-PPO combined.

Sleep Apnea Benefit—The Trust has engaged Pharmacy Value Management Solutions, Inc. to provide a program to detect and treat sleep apnea for all participants who have a Commercial Driver's License (CDL) including those in an HMO option through the Trust. Please note that spouses, dependents, and employees who do not have a CDL are not eligible for this program and should continue to use the regular benefit plan for medically necessary treatment of sleep apnea.

This benefit is available to you at no cost. The benefit recognizes that the Federal Motor Carrier Safety Administration requires that all Commercial Motor Vehicle (CMV) drivers, as a condition to renewing their CDL, must be evaluated to determine if they are experiencing sleep apnea. CMV drivers are required to see only federally-qualified Certified Medical Examiners (CMEs) to obtain their physical for this purpose. The CDL physical will include questions and a non-invasive physical exam to determine, among other things, neck size and body mass. If your Department of Transportation (DOT) examination suggests you might have sleep apnea and you are directed to get a sleep study by your company doctor, a simple but effective at-home treatment device will be sent to your home.

In the event you are directed to get a sleep study by your company doctor, you should contact SleepMaster Solutions at (844) 412-0792 and they will assist you in coordinating the sleep study and, if necessary, obtaining the equipment to treat sleep apnea. They will also facilitate the required regular reporting back to the DOT on your compliance with treatment. This is important because failure to comply may cause you to be removed from work.

WHAT YOU NEED TO DO IF YOU ARE DIRECTED TO GET A SLEEP STUDY

- **Call SleepMaster Solutions at (844) 412-0792**
- **Submit a photocopy of your Medical Examiner Certificate**

Mail to:

Pharmacy Value Management Solutions, Inc.
SleepMaster Solutions Program
2901 W. Busch Blvd. Suite 701
Tampa, FL 33618

If you have questions, please contact SleepMaster Solutions for details at (844) 412-0792 or you may also contact the Trust Administrative Office at (800) 872-5439.

Live Health Online Program—The Trust provides enhanced access to doctor visits via the Anthem Blue Cross LiveHealth Online program. The Live Health Online program enables you

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to have face-to-face conversations with board-certified doctors from your computer or mobile device at any time of day, wherever you are. There are no appointments or waiting times.

In order to use the benefit, you will need to sign up at www.livehealthonline.com and enter your insurance information. You may also download the LiveHealth Online mobile application from the App Store or Google Play. Each time you log in, you will see doctors who are currently available in your state. Once you select a doctor and click Connect, your session with that doctor will begin.

During your session, the doctor can review your health history, answer questions, assess your condition, and even prescribe prescription drugs (depending on the regulations in your state). LiveHealth Online doctors can help with many different health issues, such as:

- Colds
- Flu
- Allergies
- Sinus Infections
- Bronchitis
- Diarrhea
- Pinkeye and other eye infections
- Urinary tract infections
- Rashes

After each session, you can rate your experience and send a record from the LiveHealth Online system to your regular doctor.

For additional information regarding the LiveHealth Online program, including system requirements and frequently asked questions, please visit www.livehealthonline.com.

Indemnity Medical Benefit Exclusions

Indemnity Medical benefits are not payable for any of the following items. This applies to all medical benefits described on pages 74 to 76.

1. Services or supplies subject to the General Exclusions applicable to all benefits. See pages 74 to 76.
2. Educational services or supplies. A charge for a service or supply is not covered to the extent that it is determined by the Trust's medical consultants to be educational. For hospital stays, the length of stay and hospital services and supplies are not covered to the extent they are for education or vocational training of the patient.
3. Services related to vision: (a) exams to determine the need for (or changes of) eyeglasses or lenses of any type; (b) eyeglasses or lenses except initial replacements for loss of the natural lens; or (c) eye surgery (such as radial keratotomy or LASIK surgery) to correct myopia (near-sightedness), hyperopia (far-sightedness), or astigmatism (blurring). Medically necessary Vision Therapy is covered. See page 30. See pages 61 to 63 for a description of your vision plan.

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4. Prescription drugs purchased from a retail pharmacy, mail order pharmacy, or hospital pharmacy. These may be covered under a separately managed prescription drug program. If a prescription drug is specifically excluded under the managed prescription drug program, and is determined to be medically necessary, it may be covered under the Medical Plan. See pages 46 to 50 for a description of your prescription drug benefits.
5. Vitamins, nutritional or dietary supplements, or over-the-counter drugs or medications (whether or not prescribed by a physician).
6. Orthopedic appliances, shoes, or orthotics prescribed primarily for use during participation in sports, recreational, or similar activities.
7. Diagnosis and treatment to restore fertility or promote conception such as: in-vitro-fertilization, artificial insemination or embryo-transfer procedures, microinjections, zona drilling, or other artificial means of conception, consecutive follicular ultrasounds, cycle therapy, and corresponding laboratory tests when associated with artificial means of conception (for a covered person or surrogate as a donor or a recipient).
8. Periodontal or dental disease or any condition involving the teeth, surrounding tissue or structure, or alveolar process of the gums. This includes, but is not limited to charges for doctor's services, facility charges, and/or x-rays. This exclusion does not apply for charges made for the treatment of deteriorating teeth and gums due to radiation therapy or chemotherapy, as long as such treatment is considered medically necessary. Such coverage is limited to a \$10,000 lifetime maximum.
9. Jaw surgery, orthodontic treatment for malocclusion or TMJ (except as described on page 27).
10. Hygienic or routine foot care such as treatment of: (a) weak, strained, flat, unstable, or unbalanced feet; (b) metatarsalgia or bunions (except open cutting operations); (c) corns, calluses, or trimming of nails, except removing nail roots; and (d) care prescribed by an MD or DO treating metabolic or peripheral-vascular disease.
11. Occupational therapy, physical therapy or spinal manipulation services ordered by a physician in excess of 20 treatments each per calendar year. All services when self-referred are excluded under the plan.
12. Massage therapy services ordered by a physician in excess of 10 treatments per calendar year. All services when self-referred are excluded under the plan.
13. Acupuncture treatments in excess of 10 treatments per calendar year.
14. Expenses in connection with hearing aids, including: (a) replacement of a hearing aid for any reason more than once in a three-year period; (b) batteries or ancillary equipment other than that obtained upon purchase of the hearing aid; (c) expenses an

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- eligible person is not required to pay; or (d) repairs, servicing, or alterations of the hearing aid.
15. Long-term storage of blood other than charges associated with bone marrow transplants.
 16. Charges, services, or supplies prescribed or provided by non-covered providers.
 17. Any hospital confinement, medical, or surgical treatment to repair or treat a condition arising from a medical treatment or procedure not covered by this Plan.
 18. Supplies which are not considered by the Trust to be durable medical equipment such as air purifiers, hot tubs, waterbeds, exercise equipment, ergonomic chairs, etc., (whether or not prescribed by a physician).
 19. Services or supplies for your convenience or that of your family, or personal services such as meals for guests, telephone charges, television charges, or barber or beautician charges.
 20. Cosmetic surgery, including treatment of complications resulting from such surgery except for:
 - Accidental injuries as long as treatment occurs within 12 months of the injury.
 - Reconstruction of a breast after mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed breast.
 - Prostheses and treatment of physical complications of mastectomies including lymphedemas.
 21. To the extent coverage is not required pursuant to the Mental Health Parity and Addiction Equity Act, treatment of learning disabilities, marital family problems (including counseling), sexual disorders (including counseling), or eating disorders.
 22. Education training, or services for treatment of dyslexia, attention deficit disorders or delays in development of a child's language, cognitive, motor, or social skills. Services are provided for pervasive developmental disorder or autism. See page 29 for details.
 23. Education or training, including vocational assistance or counseling, rehabilitation, or job training or outreach, lifestyle, or fitness programs.
 24. Expenses applied to satisfy the annual plan deductible, coinsurance requirements, reduction for failing to preauthorize and similar limitations on otherwise Covered Expenses.
 25. Expenses in connection with conception, pregnancy, or delivery in connection with a surrogacy arrangement.

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26. Surgical treatment of obesity unless pre-authorized by the Trust according to Plan guidelines and received at a Blue Center of Distinction.
27. Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
28. Donor costs for a solid organ transplant or bone marrow or stem cell re-infusion that is not covered by the Trust, or for a recipient who is not a participant in this Trust.
29. Nonhuman or mechanical organs, unless it is determined they are not “Experimental/Investigational Services” according to accepted medical criteria.
30. Personal care items.
31. Anti-rejection drugs except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed. Take-home prescription drugs are covered under the Prescription Drug Benefit.
32. Transplants not provided at a Blue Center of Distinction.
33. Charges in excess of \$1,000 per day by a non-PPO Ambulatory surgical center.
34. Charges in excess of \$300 per date of service by a non-PPO laboratory (effective September 1, 2018).

Indemnity Medical Benefits Definitions

Accidental Injury—Physical harm, which is sudden and traumatic in nature, caused by the intervention of an external force at a specific time and place. It is independent of illness except for infection of a cut or wound.

Acupuncture—Treatment of an injury, illness, or condition through the use of piercing specific areas of the body along peripheral nerves with fine needles to relieve pain and for therapeutic purposes. Services must be performed by a licensed acupuncturist or qualified licensed provider performing such services.

Administrative Office—The Administrative Office retained by the Trust to provide administrative services. See page 115 for contact information.

Calendar Year—Period of one year beginning January 1 and ending December 31.

Coinsurance—The percentage of the charge you are responsible for paying.

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Cosmetic Surgery—Surgery performed to alter the texture or configuration of the skin, or any bodily feature's configuration or relationship with adjoining structures. It is performed primarily for psychological or appearance purposes and does not correct or materially improve a bodily function or treat an illness or accident.

Custodial Care—Any portion of a service, procedure, or supply that, in the Trust's judgment, is provided primarily:

- For ongoing maintenance of health and not for its therapeutic value in treating an illness or accidental injury;
- To assist the patient in meeting the activities of daily living such as help in walking, bathing, dressing, eating, preparation of special diets, and supervising self-administration of medications; and
- To sustain a patient without attempting to treat an illness or injury.

Deductible—The amount of eligible medical expenses you must satisfy each calendar year before the Trust pays medical benefits.

Doctor or Provider—A licensed or certified practitioner of the healing arts acting within the scope of his or her license in the state in which services are being provided and who meets any additional requirements established by this Plan, including, but not limited to:

- Medical Doctors; Osteopaths, Podiatrist
- Chiropractors
- Dentists
- Naturopaths
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Licensed Mental Health and Chemical Dependency Counselors
- Physicians
- Physician's Assistants
- Qualified Autism Service Provider
- Qualified Autism Service Professional
- Qualified Autism Paraprofessional
- Registered Nurse Practitioners
- Massage Therapists
- Acupuncturists (L.A.C, /OMD)
- Midwives

Durable Medical Equipment—Medically necessary equipment that can stand repeated use (except certain consumable medical supplies):

- Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury;
- Ordered and/or prescribed by a physician for the exclusive use of the patient; and
- The least costly alternative that can be safely provided.

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Experimental and Investigational—Any service, (treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply) that meets one or more of the following criteria as determined by the Trust or its medical consultants:

- A drug or device that cannot be lawfully marketed without United States Food and Drug Administration (FDA) approval and has not been granted that approval on the date it is furnished;
- A facility or provider who has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases;
- Reliable evidence shows the service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy; and/or
- Reliable evidence shows the service is not as safe and effective for a particular medical condition, as compared to other generally available services, and poses a significant risk to the patient's health or safety.

Reliable evidence means published reports and articles in authoritative medical and scientific literature, scientific results of your provider's written protocols or scientific data from another provider studying the same service.

Home Health Aide—A person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a home health care agency.

Home Health Care Agency—A hospital, agency, or other service certified to provide home health care by the proper authority of the state in which it is located.

Home Health Care Treatment Plan—A program of home care that is:

- Required as the result of sickness or injury;
- Established and reviewed at least every 60 days by the attending physician; and
- Certified by the attending physician as a replacement for hospital confinement or confinement in a skilled nursing facility that would otherwise be necessary.

The treatment plan must also describe the medically necessary services and supplies to be provided by the approved home health care agency or approved providers of service. Treatment plans are subject to periodic review by your Utilization Review Company and the Trust Administrative Office.

Hospice—A facility that provides short stays for a terminally ill person in a home-like setting for either direct care or respite care. This facility may be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program. If required by a state to be licensed, certified, or registered, the facility must also meet that requirement to be covered.

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Hospice Care Program—A program directed by a doctor to help care for a terminally ill person. This may be through:

- A centrally-administered, medically-directed, and nurse-coordinated program that provides a system of home care, uses a hospice team, and is available 24 hours a day, seven days a week; or
- Confinement in a hospice.

The program must meet standards set by the National Hospice Organization and be approved by the Trust or its medical consultants. To be considered a hospice care program, the program must also meet any state requirements to be licensed, certified, or registered.

Hospital—A legally operated institution which:

- Is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- Is supervised by a staff of doctors with 24-hour nursing service and primarily provides:
 - General inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
 - Specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a qualified hospital or specialized provider of these facilities.

The term hospital does not include a nursing home or institution (or part of one) used primarily as a facility for convalescence, nursing, rest, the aged, treatment of chemical dependency, domiciliary, custodial care (including training in daily living routines), or is operated primarily as a school.

Indemnity Medical Benefits—The term Indemnity Medical benefits refers to the benefits provided that are medical in nature and provided by medical practitioners. It does not include prescription drugs, benefits which are provided separately. In addition, it does not include any charges for services by a HMO provider if you have elected HMO coverage under the Trust.

Life Threatening—An illness, injury, or condition that, in the absence of immediate medical attention, could result in the patient's death.

Massage Therapy—Treatment of an illness, injury, or condition through massage or similar treatments when performed by a licensed massage therapist and prescribed by your physician or surgeon.

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Medical Consultant—A qualified medical professional retained by the Trust to give medical advice for determining covered services and supplies, medical necessity, and usual, customary, and reasonable (UCR) allowances.

Medically Necessary/Medical Necessity—Treatments, services, or supplies that must be ordered through a physician or other qualified provider, and are commonly and customarily recognized by the physician's profession as appropriate to treat the patient's diagnosed injury or sickness (as specified by authoritative medical or scientific literature). This must be the least costly of alternative treatments, services, or supplies that can be safely provided. It does not include maintenance or supportive treatments or services, or those that are educational, experimental, or primarily for medical or other research. The fact that any treatments, services, or supplies are furnished, prescribed, or approved by a physician or other qualified provider does not in itself mean it is medically necessary. A medical treatment, service, supply, or setting may be medically necessary in part only.

Network or Preferred Provider—A provider who has contracted with the Trust's Preferred Provider Organization (PPO). See pages 116 for a description of your PPO network.

Non-Network or Non-Preferred Provider—A provider who has not contracted with the Trust's PPO Program. See pages 116 for a description of your PPO network.

Nurse—Includes Licensed Registered Nurses (RN's), Licensed Practical Nurses (LPN's), Certified Nurse Practitioners (CRN's), and Associate Registered Nurse Practitioners (ARNP's).

Occupational Therapy—Rehabilitative treatment of an illness, injury, or condition when performed by a certified, registered, or licensed occupational therapist and prescribed by your physician or surgeon.

Out-of-Pocket Maximum—The annual limit on your portion of eligible expenses. The out-of-pocket maximum does not include deductibles, co-payments, amounts over usual, customary, and reasonable (UCR) allowances or otherwise eligible expenses not covered by the Indemnity Medical Plan.

Outpatient Care—Treatment in a non-hospital facility or by a hospital for less than 23 hours with no room and board charges.

Outpatient Surgical Center—A physician's office, medical clinic, or legally-operated institution engaged primarily in providing outpatient surgical services at the patient's expense, which meets all established standards for this kind of facility.

Physical Therapy—Treatment of an illness, injury, or condition by physical means, such as massage, hydrotherapy, heat, or similar treatments when performed by a licensed or registered physical therapist and prescribed by your physician or surgeon.

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Physician Visit—A personal interview where the physician sees the patient. Telephone consultations are not considered visits.

PPO Allowed Amount—A discounted or set negotiated rate for PPO services by a provider. The PPO Provider cannot charge the patient more for any service than the PPO allowed amount.

Preferred Provider Organization (PPO)—A network of doctors, hospitals, and other health care providers who are members of the contracted PPO. These providers furnish medical services to Trust participants at negotiated rates.

Pregnancy—Pregnancy, including resulting childbirth, abortion, or miscarriage, shall be treated as a sickness for employees and dependent wives and dependent children effective September 1, 2017

Remission—A halt in the progression of a terminal disease, or reduction in the extent that the disease has progressed.

Skilled Nursing Facility—A licensed facility having seven or more beds, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and primarily for convalescent care. It must be under the supervision of a physician and surgeon and not a home for the care of mental health/chemical dependency patients or the aged, or a rest home or place for custodial care. This includes a facility that would be classified as a skilled nursing care facility under Medicare if the facility actively sought Medicare approval.

Temporomandibular Joint Dysfunction (TMJ) and Myofascial Pain Disorder (MPD)—A disorder of the temporomandibular joint (the joint that connects the mandible or jawbone to the temporal bone) generally characterized by:

- Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, or shoulders;
- Popping or clicking of the jaw;
- Limited jaw movement or locking of the jaw; and
- Malocclusion, overbite or under-bite, and/or mastication difficulties.

Terminally Ill Person—A person whose life expectancy is six months or less, as certified by the primary attending doctor.

Totally Disabled—A person is considered totally disabled when, because of an accident or illness (including pregnancy and its complications), he or she is:

- Unable to perform the normal duties of his or her occupation;
- Not engaged in any occupation for wage or profit; or

INDEMNITY MEDICAL BENEFITS

- Under a physician's regular care for that injury or sickness.

A dependent is considered Totally Disabled when because of disability he or she is unable to engage in the normal activities of a person of the same age and gender.

Usual, Customary, and Reasonable (UCR) Charges—The maximum amount the Trust will consider for reimbursement. The amount is determined by comparing the actual charge for the services or supplies with the prevailing charges usually made by the provider when there is no health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust, its Preferred Provider Organization or other medical review organization will determine the prevailing charge.

Indemnity Medical Plan Prescription Drug Benefits

This section explains the retail and mail order prescription drug benefits available to Indemnity Plus Plan participants and their covered dependents.

The Trust's retail and mail-order prescription drug benefits are administered by Express Scripts.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

Introduction

The Trust has chosen Express Scripts to manage your prescription drug benefit. If you and your covered dependents are enrolled for indemnity medical benefits, then your prescription drug benefits are administered by Express Scripts. If you are enrolled in an HMO option through the Trust, your prescription drug coverage will be provided by your HMO. Express Scripts is the Trust's pharmacy benefit manager with a network of independent and chain pharmacy locations throughout the United States.

Only prescriptions purchased at Express Scripts network pharmacies are covered by the Trust. If you go to a retail pharmacy that is not part of the Express Scripts network, you are responsible for the full cost of the prescription.

Plan Benefits

RETAIL PHARMACY SERVICE	
There is no annual deductible for retail prescriptions. You must, however, use a participating pharmacy to receive benefits. The percentage of the drug's cost that you are responsible for is called coinsurance.	
Generic	\$15 co-pay
Preferred Brand	\$25 co-pay
Non-Preferred Brand	\$25 co-pay
Specialty Drugs	Not covered at a retail pharmacy
A maximum of up to a 34-day supply of covered medication is allowed at retail.	

HOME DELIVERY PHARMACY SERVICE	
There is no annual deductible for mail-order prescriptions. Your prescription must be dispensed by an Express Scripts home delivery pharmacy to be covered.	
Generic	\$37.50 co-pay
Preferred Brand	\$62.50 co-pay
Non-Preferred Brand	\$62.50 co-pay
Specialty Drugs	See above
A maximum of up to a 100-day supply of covered medication is allowed. Standard shipping and handling is free.	

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

Formulary: Your prescription drug benefit includes a formulary, which is a list of generic and brand-name drugs that are preferred by the Trust. This list includes a wide selection of medications and is preferred because it offers you choice while helping to keep the cost of your prescription drug benefit affordable. The medications on the formulary have been selected by an independent group of doctors and pharmacists for safety and efficacy, and only Food and Drug Administration (FDA) approved medications are included. Express Scripts may remind your doctor when a formulary medication is available instead of a medication that you are currently taking that is a non-formulary drug. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

A copy of the formulary is available from the Trust Administrative Office; or visit www.express-scripts.com or call Express Scripts at 1-800-711-0927.

Generic Prescription Drugs: Generic drugs may differ in color, size, or shape, but the Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have lower co-pays. You should ask your doctor or pharmacist whether a generic version of your medication is available and whether it would be right for you. By using a generic drug, you may be able to receive necessary medication, but reduce your out-of-pocket expenses.

How Retail Pharmacy Service Works

The retail pharmacy service is most convenient for filling your short-term prescription needs. You must use an Express Scripts participating pharmacy to receive benefits from the Trust. For example, if you need an antibiotic to treat an infection, you can go to one of the many network pharmacies. To find out whether a pharmacy participates in the Express Scripts health network:

- Ask your retail pharmacist;
- Visit www.express-scripts.com and use the online pharmacy locator; or
- Call 1-800-711-0927 (1-800-759-1089 TTY) and use the interactive pharmacy locator.

Ordering new prescriptions or refills at a network retail pharmacy:

- Show your prescription ID card at the pharmacy or provide the social security number of the WTWT employee; and
- Pay your coinsurance or co-pay (the pharmacist will tell you the amount).

At non-network pharmacies: If you go to a retail pharmacy that is not part of the Express Scripts network, you will not receive benefits from the Trust.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

How Home Delivery Pharmacy Service Works

If you need medication on an ongoing basis, such as to treat asthma or diabetes, you can ask your doctor to prescribe up to a 100-day supply for home delivery, plus refills for up to one year (as appropriate). You will pay just one co-pay for each prescription or refill. Since you can get a larger supply of medication through the home delivery pharmacy service than at a participating retail pharmacy, you may save money.

With the Home Delivery Pharmacy Service

- Your medications are dispensed by one of the pharmacists in Express Scripts network of home delivery pharmacies;
- Medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an added charge);
- You can track your prescriptions online at www.express-scripts.com, or by calling 1-800-711-0927 (1-800-759-1089 TTY); and
- Registered pharmacists are available around-the-clock for medication consultations.

Using Home Delivery Pharmacy Service for the First Time: Ask your doctor to write a new prescription for up to a 100-day supply, plus refills for up to one year (if appropriate). Prescriptions may be submitted:

- **By mail**—Send the new prescription(s), along with an *Express Scripts Health Home Delivery Pharmacy Service Order Form* and the appropriate co-pay, to Express Scripts in the return envelope. You can print an order form from the www.express-scripts.com website.
- **By fax**—Ask your doctor to call 1-888-327-9791 for instructions on how to fax a prescription. Only your doctor may fax a prescription. Be sure to give your doctor your Member ID number. You will be billed later.
- **Online**—Visit www.express-scripts.com. Once you are registered and logged in, scroll to the bottom of the “order center,” click on the “request a new prescription from your doctor” link, and follow the on-screen instructions.

Your medication will be delivered within 7 to 11 days after mailing your order. When placing your order, you should have at least a 14-day supply of medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply to be filled at your local participating retail pharmacy.

You can request additional Home Delivery Pharmacy Service Order Forms and envelopes at www.express-scripts.com, or by calling 1-800-711-0927.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

Refilling Your Prescription: You can refill your home delivery prescriptions online, by telephone, or by mail. Have your Member ID number and your prescription number for the medication. If you choose to pay by credit card, please have that number available as well.

- **Online**—Each time registered users log in to www.express-scripts.com, available prescription refills will be displayed in the personalized “order center,” as well as within your prescription history. From the order center, simply check the box next to the items you want to order and follow the on-screen instructions to check out.
- **By telephone**—Call 1-800-473-3455 to use the automated refill system.
- **By mail**—Use the refill order form that will accompany your prescription. Mail it along with your co-pay to Express Scripts in the return envelope.

To make sure that you do not run out of your medication, remember to reorder 14 days before your medication runs out. You can find the refill date on your prescription bottle, on the refill slip that comes with every order, or at www.express-scripts.com.

Paying for Your Medication: You may pay your portion of the cost by check, money order, or credit or debit card.

Covered Prescriptions

The following drugs, medicines, and supplies are covered when prescribed by a physician, dentist, osteopath, or podiatrist within the scope of his or her license and meet the other Plan requirements such as medical necessity criteria:

- Legend drugs requiring a prescription (any medicine labeled “Caution: federal law prohibits dispensing without a prescription”);
- Some drugs or medicines available without a prescription, including the following “over the counter” (OTC) medications: dental fluoride products, antacids, elixir terpin hydrate, epinephrine, ephedrine, ferrous sulfate/fumarate (selected products), and cough medications;
- Diabetic supplies including insulin, syringes, needles, test tapes or strips, acetone test tablets, Benedict’s solution or equivalent, lancets, or similar test supplies;
- Oral, transdermal, intravaginal, and injectable contraceptives (but not contraceptive devices such as diaphragms or cervical caps);
- Myeloid stimulants;
- Erectile dysfunction medications for males over age 18. These prescriptions are subject to quantity limitations of:
 - Retail pharmacy—12 tablets per rolling 34 calendar days;

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

- Home delivery – 40 tablets per rolling 100 calendar days.
- Pediatric fluoride vitamins; and
- Cosmetic dermatologicals such as Retin-A/Avita and Tazorac cream through age 34.

In addition, some prescription drugs require pre-authorization by the Trust. Examples are drugs used to treat rheumatoid arthritis, medical Botox, and Myobloc.

Prescription Benefit Management Program

The Trust utilizes Express Scripts to provide various programs including: Preferred Step Therapy; Diabetes Home Testing Program; Express Scripts Research Institute Research Opportunities; Personalized Medical Program; and, prior authorization. Further information on these programs is available from Express Scripts.

Compound Medications – Coverage Limited

Your prescription drug benefit does not cover prescriptions for certain compound medications. The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix, or alter the ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications.

In order for a compound drug to be covered under your prescription drug benefit, it must satisfy the following conditions:

- The compound drug must be deemed medically necessary, and not be considered experimental or investigative;
- The compound drug must not contain any ingredient on the list of excluded ingredients. A comprehensive list of excluded ingredients is available from Express Scripts; and
- The cost of the compound must be determined by Express Scripts to be reasonable.

To obtain information on whether a particular compound drug is covered under your prescription drug benefit, please contact Express Scripts using the number located on your member ID card.

Prescription Drug Benefit Exclusions

The prescription drug benefit program *does not cover* the following:

1. Services or supplies (including drugs) subject to the General Exclusions applicable to all benefits. See pages 74 to 78.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

2. More than a 34-day supply of medication for retail pharmacy prescriptions or a 100-day supply for home delivery service.
3. Drugs or medicines procured or procurable without a physician's prescription, including all over-the-counter drugs, (except as described in Covered Prescriptions on page 49).
4. Drugs to treat conditions, including experimental uses that are not within uses approved by the FDA or the manufacturer.
5. Medications, drugs, or supplies that are compensated for or furnished by any workers' compensation, occupational disease law, or state or governmental agency.
6. Any prescription or refill that individually, or cumulatively over time, exceeds dosages approved by the Food and Drug Administration (FDA) or manufacturer recommendations.
7. Drugs dispensed in a hospital, nursing home, clinic, ambulatory surgical center, physician's office, or other institution.
8. Drugs prescribed or purchased after coverage terminates.
9. Devices used to administer drugs (except as described in Covered Prescription Drugs).
10. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs.
11. Charges for the administration or injection of any drug.
12. Contraceptive jellies, creams, foams, or implant devices.
13. Biologicals, immunization agents, or vaccines.
14. Therapeutic devices or appliances (canes, crutches, walkers, etc.).
15. Blood glucose monitors and glucoWatch/sensors (may be covered under Plan's medical benefits).
16. Mifeprex.
17. Drugs used to restore fertility or promote conception.
18. Blood or blood plasma products.
19. Any non-drug item, proprietary medicines, allergy sera, dietary supplements, vitamins (except pediatric fluoride vitamins), or health and beauty aids.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS

- 20. Prescriptions refilled above the number of refills specified by the physician or any refill dispensed after one year from the physician's original order.
- 21. Injectable chemotherapy drugs (may be covered under the Plan's medical benefits).
- 22. Smoking cessation products.
- 23. Cosmetic purpose drugs such as Minoxidil or Botox.
- 24. Substance abuse treatment drugs such as Methadone, Antabuse, Rexia, Subutex, or Suboxone.

Coordination of Benefits: Benefits for prescription drugs are not coordinated with other plans. The Trust will not provide benefits if benefits have been provided for a prescription under another plan.

Indemnity Dental Benefits

This section explains the dental benefits available to Indemnity Plus Plan participants and their covered dependents.

INDEMNITY DENTAL BENEFITS

Indemnity Dental Benefits for You and Your Covered Dependents

You may choose a dental plan either at the time you become initially eligible or during the Trust's annual open enrollment period. If you do not make an election, you will be placed automatically in the Trust's indemnity Dental Plan. If you previously chose an alternate dental plan, you will continue to participate in that plan until you revoke your election. You and your dependents must participate in the same dental plan.

Alternate Dental Plan Options: Alternate dental plans are available for employees and dependents living in the areas serviced by the providers listed below:

- LIBERTY Dental Plan – California.
- Kaiser Foundation Health Plan of Oregon – Oregon and Southwest Washington.

These alternate dental plans are described in separate booklets provided by the alternate dental provider. Contact the Trust Administrative Office if you have questions.

Indemnity Dental Plan Benefits

The dental benefits described in this Booklet are your dental benefits if you did not elect to enroll in one of the alternate dental plans above. The dental benefits in this section are provided and funded by the Trust.

The Trust reimburses you, or your provider, for covered dental services provided to you or your eligible dependents up to the PPO allowed amount or the usual, customary, and reasonable (UCR) allowable amount subject to the following provisions and exclusions.

Effective January 1, 2018, the Trust has contracted with Anthem Blue Cross to provide a dental PPO network to the Trust. Anthem, as a dental PPO contracts with a large number of dental providers at fees typically lower than usual, customary and reasonable (UCR) fees, which provide savings on most dental procedures including routine oral exams, cleanings and major work, such as dentures, root canals and crowns. A dental PPO helps you obtain dental care at prearranged rates by contracting with dentists in its "network" offering significant discounts on most dental procedures.

Using a PPO Provider does not require special enrollment. To locate a participating dental provider, please call (800) 872-5439 or visit www.anthem.com to locate dental providers in the Anthem network. You may use dental providers that are not in the Anthem network, but it will result in payments being made at the Non-PPO level.

Calendar Year Deductible: Effective with services provided on or after January 1, 2018, there is no calendar year deductible. Previously, you and each of your covered dependents were

INDEMNITY DENTAL BENEFITS

required to pay a calendar year deductible of \$50 in eligible expenses before the Trust Dental Plan pays benefits.

Usual, Customary, and Reasonable (UCR): Usual, customary, and reasonable means the maximum amount the Trust will consider for non-PPO reimbursement. The amount is determined by comparing the actual charge for the services or supplies with the prevailing charges usually made by the non-PPO Provider when there is not health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust or its medical consultants will determine the prevailing charge.

Annual Benefit Maximum: The maximum payment is \$2,000 per covered person each calendar year for children 18 and older and participants and spouses regardless of age. There is no annual maximum on necessary dental services (preventive, basic and major restorative) provided to children younger than age 18.

Payment Levels: The Trust will reimburse the fee charged by the PPO dentist for eligible services at the PPO rate or, for non-PPO providers, up to the usual, customary, and reasonable (UCR) allowable amount, at the levels shown below. If more than one dentist provides services in connection with a dental service performed on an individual, the benefit will not exceed the amount that would be payable if such service had been provided by only one dentist.

PAYMENT LEVELS FOR BENEFITS		
	PPO Provider	Non-PPO Provider
Preventive Care	100% of contracted rate	85% of usual, customary, and reasonable (UCR) costs
Basic Care	100% of contracted rate	80% of usual, customary, and reasonable (UCR) costs
Major Restorative	100% of contracted rate	50% of usual, customary, and reasonable (UCR) costs

Predetermination of Benefits: If your dental work is likely to cost over \$200, it is recommended you ask your dentist to send a treatment plan to the Trust Administrative Office before beginning your dental work. This “predetermination of benefits” will allow you to know how much the Trust will pay toward your dental work, and help you budget for your out-of-pocket dental expenses. The Trust Administrative Office will let you and your dentist know ahead of time the estimated amount that will be covered by the Trust.

Covered Dental Services: For a dental charge to be covered, it must be performed by a legally qualified dentist, licensed dental hygienist working under the direction of a legally qualified dentist, or a licensed denturist providing services within the scope of his or her license.

INDEMNITY DENTAL BENEFITS

The following charges, up to PPO network allowable or up to the usual, customary, and reasonable (UCR) allowable amount, are covered dental services:

- Oral examination (including emergency exams), two per calendar year;
- Prophylaxis and periodontal maintenance, two per calendar year;
- Topical application of fluoride for children through age 18, one application per child per calendar year;
- Sealants for children through age 18, once in any three-year period per tooth. Also limited to first and second molars with no previous cavities;
- X-rays:
 - Full mouth set of x-rays, including panoramic, one series per calendar year;
 - Bite wing x-rays, two sets per calendar year;
- Space maintainers for children under age 13;
- Extractions;
- Restorative type fillings;
- General anesthetic when administered with oral surgery (certain guidelines apply);
- Treatment of periodontal and other diseases of the gums and tissues supporting the teeth;
- Endodontic treatment, including root canal, if tooth is opened while the patient is covered by the Trust;
- Re-cementing of crowns, inlays, and bridgework;
- Relining of dentures;
- Emergency palliative treatment;
- Inlays, onlays, gold fillings, or crowns when teeth cannot be restored with a filling material, or where the tooth serves as an abutment for a bridge;
- Initial installation of full or partial dentures, dental implants, and fixed bridgework, including inlays, and crowns, to replace one or more natural teeth; and
- Replacement of existing bridgework or implants by new bridgework or implants, or the addition of teeth to existing dentures or bridgework, only if the existing denture, bridgework, or implant cannot be made serviceable and was installed more than five years ago.

Indemnity Dental Benefit Exclusions

Indemnity Dental benefits are not payable for any of the following items:

INDEMNITY DENTAL BENEFITS

1. Services or supplies subject to the General Exclusion applicable to all benefits. See pages 74 to 76.
2. Jaw treatment for temporomandibular joint dysfunction (TMJ), and myofascial pain dysfunction (MPD). Coverage may be available or provided under the Trust's medical benefits. See page 27.
3. Anything not furnished by a dentist, except:
 - X-rays ordered by a dentist;
 - Services provided by a licensed hygienist under a dentist's supervision; and
 - Services and supplies provided by a licensed denturist.
4. Expenses for orthodontic services and supplies for adults (a program to straighten teeth) or furnished for cosmetic purposes unless medically necessary as a result of an accidental injury while the patient is covered by the Trust. See page 58 for orthodontic benefits for covered dependent children.
5. Replacement of lost or stolen appliances, appliances, or restorations for the purpose of splinting to increase vertical dimension or restore occlusion.
6. An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge, or gold restoration for which the tooth was prepared before the patient was covered; and root canal therapy if the pulp chamber was opened before the patient was covered.
7. A crown, gold restoration, denture, dental implant, fixed bridge, or addition of teeth to a fixed bridge, if the work involves a replacement or modification of a crown, gold restoration, denture, dental implant, or bridge installed less than five years before and for which a benefit was payable under the Dental Expense Benefit. This exclusion does not apply if the replacement and modification of a crown of less than five years is due to dentally necessary treatment of the underlying tooth or structure and the existing crown cannot be saved.
8. The replacement of a partial or full removable denture or fixed bridgework if denture or bridgework can be satisfactorily repaired.
9. Procedures that were started prior to the individual becoming covered by the Trust Dental Plan.
10. Charges for broken appointments with a dental provider.
11. Charges for treatments, materials, or supplies that are experimental or investigational in nature.

INDEMNITY DENTAL BENEFITS

Dental charges not payable under the dental plan, or in excess of the usual, customary, and reasonable (UCR) allowable amount, are not eligible expenses under the Trust's medical benefits. These charges may not be used to satisfy the indemnity Medical benefit plan deductible except for charges incurred for certain dental services (see a description of Dental services covered under the indemnity medical Plan on page 35), and then only to the extent that they are eligible expenses under the Trust's indemnity medical plan.

Administration of Dental Benefits/Extended Benefits: Certain dental procedures (such as crowns, inlays, dentures, etc.) can involve a delay between when an impression is taken and the prosthetic is delivered or seated. To receive benefits in such situations, you must be eligible on both the date the impression is taken and on the date when the prosthetic is delivered or seated (subject to the one-month extension available under the Extended Benefit provision discussed below). Benefits are determined on the date that the prosthetic is seated or delivered and are applied toward the Annual Benefit Maximum based on that date as well.

Extended Dental Benefits: If your dental coverage terminates and you or your covered dependent are under the care of a dentist, the benefits will be extended one month for any eligible dental service that was already started, provided the work is done by the same dentist and benefits would have been paid had your Trust dental coverage remained in effect. In no event will diagnosis, prophylaxis, or the taking of x-rays constitute a service started. This extension does not apply to orthodontic benefits. When this Extended Benefits provision applies, it will operate only to the extent that coverage is not otherwise provided for the person through the Trust.

Orthodontic Benefit for Your Covered Dependent Children

This benefit applies to active orthodontic treatment to straighten teeth for a child who is covered under the Trust Dental Plan.

SCHEDULE OF BENEFITS	
Benefit Percentage	50% of eligible charges
Lifetime Maximum, Per Child	\$1,500

A child must be covered for the month the service is provided for benefits to be payable. In no event will the benefits be greater than the dentist's charges for the treatment.

For purposes of determining benefits, the treatment period begins when an active appliance is installed and ends when the appliance is removed.

Covered Orthodontic Services

- X-rays ordered by a dentist;
- Services provided by a licensed dental hygienist under a dentist's supervision; and

INDEMNITY DENTAL BENEFITS

- Services and supplies provided by a licensed or certified dentist.

How Benefits Are Paid: Orthodontic benefits are paid at 50% when orthodontic bands are installed and then 50% of eligible charges on a monthly basis.

Orthodontic Benefit Exclusions: The orthodontic benefit under this Plan does not cover:

- The Participant or Spouse;
- Services or supplies subject to the General Exclusions applicable to all plans. See pages 74 to 76;
- Services or supplies provided by a non-dentist;
- Services and supplies not necessary or customarily provided for dental care; and
- Charges incurred after an active appliance is removed.

Status as Limited Scope Plans: The Trust offers dental and vision to Employees. The Affordable Care Act exempts limited scope dental and vision benefits from certain statutory requirements. To qualify, a self-funded dental and vision plan must either be insured or have a provision allowing an individual to opt out of dental and vision coverage. The Trust allows you to opt out of dental coverage on an annual basis. If you opt out, it will not result in any lower employer contribution and it will not result in any additional compensation going to you. If you want additional information about the dental opt out, please contact the Trust Administrative Office.

Vision Care Benefits

This section explains the vision benefits available to all Indemnity Plus Plan participants and their covered dependents.

The Trust's vision benefits are administered by Vision Service Plan.

VISION CARE BENEFITS

Vision Care Benefits for You and Your Covered Dependents

Your vision care plan, provided and administered by Vision Service Plan (VSP), features a network of over 35,250 doctor access points nationwide, that provide professional vision care for participants and their dependents covered under the Plan. This assures professional eye care and eyewear at a uniform cost.

How to Use the Plan When Care Is Provided by a VSP Network Doctor

When using a VSP network doctor, you and your eligible dependents have the following benefits:

Vision Examination: A complete analysis of the eyes and related structures to determine the presence of vision problems, abnormalities, or to determine the need for corrective lenses. Available every 12 months from the last date of service and covered in full by the Trust after a \$15 co-pay.

Lenses: The VSP network doctor will order the proper lenses. The program provides quality lenses fabricated to exacting standards. The VSP doctor also verifies the accuracy of the finished lenses. Available every 12 months from the last date of service and covered in full by the Trust after a \$25 co-pay (combined with frames). Any cosmetic lens option will be an out-of-pocket expense to the patient. There is an average 30% savings on lens options like progressives, scratch-resistant, and anti-reflective coatings.

Frames: The Plan offers a wide selection of frames. However, if you select a frame that costs more than the Plan allowance (or a large frame that requires oversize lenses), you will be responsible for the additional charge. Frames are available every 24 months from the last date of service. A frame of your choice is covered up to \$150 if received from a VSP provider, plus 20% of any out-of-pocket cost. The \$25 materials co-pay will apply (combined with lenses).

Contact Lenses: You may choose contacts instead of prescription glasses. Contact lenses of your choice are covered up to \$130 if offered from an in-network provider. If you choose contact lenses you will receive a full contact lens exam after a co-pay of \$60.00. You will receive a 15% discount on all other contact lens exam services. The contact lens exam is in addition to your routine vision exam to ensure proper fit of your contacts available every 12 months from the last date of service.

In addition to the benefits above, VSP also provides the following extra discounts and savings when you use a VSP network doctor:

Prescription Glasses

- 20% discount on additional prescription glasses and sunglasses;

VISION CARE BENEFITS

- 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.

Contacts

- 15% discount on the cost of your contact lens exam (fitting and evaluation). The contact lens exam discount applies to the doctor's professional fee that includes fitting and evaluation to ensure proper fit of contacts. Discount does not apply to contact lens purchase;
- Exclusive pricing for an annual supply of contact lenses is available for many popular brands.

Laser Vision Correction Discount: VSP has arranged for members to receive PRK, LASIK, and Custom LASIK at a discounted fee from VSP network doctors. You will receive an average 15% discount on the contracted laser center's usual and customary price or 5% off the promotion price from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor within 12 months of your last eye exam.

Benefit Co-Payments: When you select a doctor from the VSP network, your exam, professional services, lenses, and frames will be subject to the following co-pays:

CO-PAYS	
Exam	\$15 co-pay
Lenses and/or frames*	\$25 co-pay
Contacts	Up to \$60 co-pay
* If you select a frame that costs more than the Plan allowance, you will be responsible for the additional cost.	

Co-pays should be paid to the VSP network doctor at the time of the service. Payment for additional care, service, and/or eyewear not covered by this Plan may be arranged between you and your doctor.

Accessing Care and Receiving Benefits from VSP Network Doctors

1. To find a VSP network doctor, call VSP at 800-877-7195 or visit www.vsp.com.
2. Make an appointment with your VSP network doctor. Identify yourself as a VSP member and give the Trust participant's social security number. Your doctor and VSP will handle the rest.
3. You pay the doctor a \$15 co-pay for the exam and a \$25 co-pay if you purchase lenses and/or frames.

VISION CARE BENEFITS

4. You do not need to file any claim forms.

How to Use the Plan for Non-VSP Provider Care: If you choose to use a non-VSP optometrist, ophthalmologist, or dispensing optician, benefits are provided based on the non-VSP provider reimbursement schedule and co-pays still apply.

If you choose to use a non-VSP provider, you pay the provider in full at the time of service. You will be reimbursed by VSP up to the fee schedule below after a \$15 co-pay for exam services and a \$25 co-pay for lenses and/or frames. There is no assurance that this will cover all the expenses.

NON-VSP PROVIDER	
COVERED SERVICE	PLAN PAYS UP TO
Vision Exam , available every 12 months	\$27.50
Lenses and Frames, Per Pair	
Single Vision Lenses, available every 12 months	\$31.00
Bifocal Lenses (lined), available every 12 months	\$48.00
Trifocal Lenses (lined), available every 12 months	\$58.00
Frames, available every 24 months	\$50.00
Eye Exam, Fitting & Evaluation and Contacts	
Available every 12 months	\$90.00

Availability of service under this reimbursement schedule is subject to the same time limits as those described for VSP network doctors, and are in lieu of obtaining these services from a VSP network doctor.

Extra Cost Items

This Plan is designed to cover your visual rather than cosmetic needs. You pay for:

- Blended lenses;
- Contact lenses (except as noted elsewhere herein);
- Oversize lenses (61 mm or larger);
- Progressive multi-focal lenses;
- Coated lenses;
- Laminated lenses; and
- A frame that costs more than the Plan allowance.

VISION CARE BENEFITS

Vision Benefit Exclusions

Vision care benefits are not payable for any of the following items:

1. Services or eyewear subject to the General Exclusions applicable to all benefits. See pages 74 to 76.
2. Orthotics or vision training and any associated supplemental testing.
3. Plano lenses.
4. Two pair of glasses instead of bifocals.
5. Lenses and frames provided under this Plan that are lost or broken will not be replaced except at normal intervals when services are otherwise available.
6. Medical or surgical treatment of the eyes (may be covered under the medical plan).
7. Any eye exam or corrective eye wear required by an employer as a condition of employment.
8. Subnormal vision aids.

VSP may, at its discretion, waive any of the limitations if, in the opinion of our optometric consultants, it is necessary for the visual welfare of the covered person.

Filing a Vision Care Claim for Reimbursement: For timely reimbursement, go online to www.vsp.com, select the *Out-of-Network Reimbursement Form*, and follow the instructions. If you do not have internet access, send your itemized statement of charges to VSP with the participant's name, social security number, the patient's name, date of birth, and relationship to the participant, and state that your coverage is under the Western Teamsters Welfare Trust. Your claim must be submitted within 12 months of completion of services. Keep a copy of the claim and submit your originals to:

VSP
P.O.Box 385018
Birmingham, AL 35238-5018

If you have any questions, call VSP at 800-877-7195.

Processing Vision Care Claims: VSP will pay or deny claims for Plan benefits provided to you and your eligible dependents, after any co-pay, within 30 days after VSP receives a completed claim, unless special circumstances require additional time. In this case, VSP may obtain an extension of 15 days by providing notice of the reasons for the extension.

VISION CARE BENEFITS

Appeal of Denied Claims: Under the Plan, if a claim is denied in whole or in part, you or your authorized representative may request a full review of the denial. You may designate any person, including your provider, as your authorized representative.

Initial Appeal: The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Trust participant for whom the claim was denied, including the VSP enrollee's name, the VSP enrollee's member identification number, the Trust participant's name and date of birth, the provider's name, and the claim number. You may review during normal working hours any documents held by VSP pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, will be provided and communicated to you as follows:

- Prior authorization for visually necessary or appropriate services: within 30 calendar days after receipt of your request for an appeal; and
- Denied claims for services rendered: within 30 calendar days after receipt of your or your authorized representative's request for an appeal.

Second Level Appeal: If you or your authorized representative disagree with the response to the initial appeal of the claim, you or your authorized representative have the right to a second level appeal. Within 60 days after receipt of VSP's response to the initial appeal, you or your authorized representative may submit a second appeal to VSP along with any pertinent documentation. VSP will communicate its final determination to you or your authorized representative in compliance with applicable state and federal laws and regulations and will include the specific reasons for the determination.

Other Remedies: If you remain dissatisfied after completing the VSP appeals process, you may request the Trust's Board of Appeals to review your appeal. Details about how to access the Trust Claims Appeal Procedure are set forth on pages 83 to 91. Additionally, under the provisions of ERISA, you or your authorized representative have the right to bring a civil action after you have exhausted the Claims Appeal Procedure.

Status as Limited Scope Plans: The Trust offers dental and vision to some groups. The Affordable Care Act exempts limited scope dental and vision benefits from certain statutory requirements. To qualify, a self-funded dental and vision plan must either be insured or have a provision allowing an individual to opt out of dental and vision coverage. The Trust has an opt out provision. If you opt out, it will not result in any lower employer contribution and it will not result in any additional compensation going to you. If you want additional information about the vision opt out, please contact the Trust Administrative Office.



Life and Accidental Death and Dismemberment (AD&D) Benefits

This section explains the life and accidental death and dismemberment benefits available to Indemnity Plus Plan participants and their covered dependents. The Trust's life and AD&D insurance benefits for employees are provided through a contract with Voya. The Trust's dependent life coverage is self-funded.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Employee Term Life Insurance

SCHEDULED BENEFIT	
Employees	\$15,000 for losses January 1, 2019 or later

Death Benefit: If you die from any cause while insured for Term Life Insurance under this Plan, your beneficiary will receive the scheduled benefit in effect on the date of your death. If your beneficiary does not survive you, or if you have not designated a beneficiary, Voya will pay benefits in the following order:

- Your spouse, if living, otherwise;
- your surviving natural or adopted children in equal shares; then,
- your surviving parents in equal shares; then,
- your surviving brother(s) and sister(s) in equal shares; then,
- your executors or administrators.

Designation of Beneficiary: You may designate a beneficiary by making the request in writing to the Trust Administrative Office. You may change your beneficiary whenever you wish by submitting a new written request.

Insurance During Total Disability: If you become totally disabled before you reach age 60, the Trust will continue your Term Life Insurance until you reach age 65, at no cost to you, as long as you remain totally disabled. You must submit written proof of your total disability to Voya no later than one year after the date you became disabled. You will be required to submit proof of your disability each subsequent year. The provision will cease under certain conditions. However, in no event will it continue past age 65.

If you become totally disabled while age 60 or over, your Term Life Insurance will become payable if you die within 12 months from the date your insurance terminates (when premium payments cease), provided you were continuously disabled to the date of death and the group policy has not terminated.

Changing to an Individual Policy: During the 31 days following termination of your coverage under the Trust, you may change your Term Life Insurance, without having to furnish evidence of good health, to one of a number of individual life policies, excluding Term Life Insurance. The policy will be effective at the end of the 31-day period, and the premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. If you die during this 31-day period, your Term Life Insurance will be paid whether or not you have applied for an individual policy.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Should you become eligible again, you may not avail yourself of this provision if an individual policy is in effect as a result of a previous conversion.

These provisions for change to an individual policy will not be applicable if your insurance is continued as a result of an approved total disability, except in the event you recover from such total disability and apply for the individual policy within 31 days of such recovery.

Life Coverage for Covered Dependents – Spouse and Child (ren)

The following amount will be paid to you (the employee), if one of your covered dependents dies. Life coverage for covered dependent children takes effect after he or she is 14 days old. The life benefit for spouse and children are paid from Trust assets and are not insured.

SCHEDULED BENEFIT	
Spouse and each child	\$1,000 for losses January 1, 2019 or later

Employee Accidental Death and Dismemberment Insurance

The following amount will be paid for any of the losses listed below that are caused solely by external, violent, and accidental means on or off the job while you are insured. It is payable regardless of other insurance.

SCHEDULED BENEFIT	
All Employees	Up to \$15,000 for losses January 1, 2019 or later

LOSS	BENEFIT AMOUNT
Loss of Life	Full amount of Scheduled Benefit (paid to your Life insurance beneficiary)
Loss of: Both hands Both feet Sight of both eye One hand and one foot One hand and sight of one eye	Full amount of Scheduled Benefit (paid to you)

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

LOSS	BENEFIT AMOUNT
One foot and sight of one eye	
Loss of: One hand One foot Sight of one eye	One-half the amount of Scheduled Benefit (paid to you)

Loss of sight means total and irrecoverable loss of sight. Loss of a hand or foot means loss by severance at or above the wrist or ankle.

AD&D Limitations: The total payment for all losses due to any one accident will not be more than the full amount of the scheduled benefit. The loss must take place within 90 days of the accident.

AD&D Benefit Exclusions

Accidental death and dismemberment insurance does not cover a loss which results from, or is caused directly or indirectly by:

1. Suicide, whether sane or insane.
2. Body or mental infirmity or disease, or medical or surgical treatment thereof.
3. Ptomaine or bacterial infection, except only septic infection of and through a visible wound accidentally sustained.
4. Any state of war, any act of war, an insurrection, or participation in a riot.
5. Travel in, or descent from, any aircraft aboard which you have any duties or give or receive any training.



Time Loss Benefits—Employees Residing Outside California

This section explains the time loss benefits which are available only to Indemnity Plus Plan participants living outside California.

Weekly time loss benefits are funded by the Trust.

TIME LOSS BENEFITS—EMPLOYEES RESIDING OUTSIDE CALIFORNIA

Weekly Time Loss Benefits for Employees Outside California

Only Employees who live outside California are eligible to receive Time Loss benefits.

You will receive weekly payments if you are unable to work because of a covered, non-occupational accident or sickness. You must be under the regular care of a doctor and the disability must begin while you are eligible under the Trust for this benefit.

SCHEDULED BENEFIT	
Weekly Benefit (subject to FICA withholding)	\$150

PERIOD OF DISABILITY PRIOR TO BENEFIT PAYMENTS	
If Disability Results From: an Accident a Sickness an Inpatient Hospital Confinement	Benefits Begin: on the first day of disability. on the eighth consecutive day of disability*. on the first day of confinement if during the seven-day waiting period.

*The seven-day waiting period begins on the day following your last day worked and the first day you are certified as disabled by a physician.

Maximum Benefit Payment Period: Payments will continue as long as you are disabled, to a maximum of 26 weeks for any one period of disability (including disability due to pregnancy).

Periods of disability due to the same cause will be considered the same period of disability unless they are separated by return to active, full-time work for at least two weeks. Periods of disability due to different causes will be considered different periods of disability if they are separated by return to active full-time work for at least 2 weeks.

Time Loss Benefit Exclusions

The Weekly Time Loss Benefits do not cover:

1. Time loss situations which are referred to in the General Exclusions applicable to all benefits. See pages 74 to 76.

TIME LOSS BENEFITS—EMPLOYEES RESIDING OUTSIDE CALIFORNIA

2. Any period you are receiving old age insurance benefits under Social Security or age/disability retirement benefits under any Teamster Pension Plan.
3. Disabilities due to injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any workers' compensation law, occupational disease law, or similar legislation.
4. Disabilities due to injury or illness which are or appear to be the responsibility of one or more third parties.

General Exclusions

This section applies to all benefits previously described in this Booklet.

GENERAL EXCLUSIONS

General Exclusions Applicable to All Benefits

All benefits described in this Booklet are subject to the following general exclusions. Benefits are not payable for:

1. Services or supplies obtained or Time Loss incurred when the individual is not eligible under the Trust.
2. Services or supplies determined not to be medically or dentally necessary. Medically or dentally necessary means that services or supplies (a) must be ordered through a physician or other qualified provider recognized as an eligible provider under the Plan, (b) must be commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed injury or sickness as specified by authoritative medical or scientific literature, and (c) must be the least costly of the alternative services or supplies which can be safely provided. Medical necessity does not include maintenance or supportive type treatment or services. Such services or supplies must not be educational or experimental in nature or provided primarily for the purpose of medical or other research. The fact that a service or supply was furnished, prescribed, or approved by a physician or other qualified provider does not in itself mean it was medically necessary. A medical service, supply, or setting may be medically necessary in part only. The Trust has authorized its medical and dental claims payor, PPO network providers, and other benefit review organizations to utilize their internal guidelines, protocols, and procedures to determine the medical or dental necessity for services under the Plan.
3. Any expense or charge for which you or a covered dependent are not financially responsible.
4. The portion of a charge for a service or supply in excess of the usual, customary, and reasonable charge. Usual, customary, and reasonable means the maximum amount the Trust will consider for reimbursement. The amount is determined by the terms of a providers contract with a PPO organization or by comparing the actual charge for the services or supplies with the prevailing charges usually made by the provider when there is not health care coverage. This is not to exceed the prevailing charge in the same geographic area as the provider, for services of the same nature and duration, and performed by a person of similar training and experience, or for substantially equivalent supplies. The Trust has authorized its claims payors, PPO network providers, and medical review organizations to utilize their established criteria to determine usual, customary and reasonable charges for network and out-of-network providers.
5. Any expenses or charges for services or supplies which are considered experimental or investigational treatment, as determined by the Trust or its claims payors, PPO network providers, or other benefit review organizations. Experimental or investigational treatment means any services, including a treatment, procedure, facility, equipment, drug, drug usage, medical device, or supplies that, as determined by the Trust or its medical consultants, meets one or more of the following criteria:

GENERAL EXCLUSIONS

- A drug or device that cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date it is furnished;
 - A facility or provider that has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases;
 - Reliable evidence shows the service is not safe and effective for a particular medical condition, as compared to other generally available services, and that it poses a significant risk to the patient's health or safety; and
 - Reliable evidence means only published reports and articles in authoritative medical and scientific literature, scientific results of the provider of care's written protocols, or scientific data from another provider studying the same service.
6. Services or supplies obtained or time loss incurred as a result of an injury or illness, which is covered under a workers' compensation program or where a claim for such coverage has been made. However, where a contested claim for workers' compensation is pending, benefits otherwise subject to this exclusion may be paid if you or your dependent observe the Trust's requirements for advancement of benefits. See Advancement of Benefits provision on page 81.
7. Services or supplies obtained or time loss incurred as a result of an injury or illness which is, or appears to be, the responsibility of one or more third parties and for which payment is or may be made by a third party, or by one or more insurance companies whose insurance policies have become applicable. The term insurance includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability, homeowner's liability, umbrella liability, and medical payments or PIP coverages, regardless of whether such insurance is maintained by the injured person, by a third party, or by any other person or entity. However, where a third-party claim is pending, benefits otherwise subject to this exclusion may be paid if you or your dependent observes the Trust's requirements for advancement of benefits. See Advancement of Benefits provision on page 81.
8. Services or supplies or time loss payments furnished by or for a federal, state, or other governmental agency, unless the Trust is required to pay by applicable law, or to the extent benefits are provided under any governmental program or law under which the individual is or could be covered. This exception does not apply to state plans under Medicaid or to any law or governmental plan which states that its benefits are excess to those of any private insurance program or other non-governmental program.
9. Services, supplies, or time loss payments required for an injury or illness or any loss incurred as a result of military service or as a result of an act of war.
10. Services or supplies for treating an injury or illness while legally confined in a penal institution, mental hospital, or other government facility, or during participation in criminal activities.

GENERAL EXCLUSIONS

11. Charges for any services rendered by you, your spouse, or any member of your immediate family.
12. Claims for services or supplies, or time loss not submitted to the claims payor within 12 months of the date the services or supplies are provided or the disability or death has taken place. Time Loss/disability and death benefits must be submitted via completion of applicable forms that can be obtained from the Trust Administrative Office.
13. Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipient, and on cadavers.

Services or supplies used in these General Exclusions include prescription drugs.

These general exclusions apply to all benefits described in this Booklet. Additionally, you should check the specific exclusions for each type of benefit offered by the Trust. Specific exclusions are contained in the following pages of your Booklet:

<u>Specific Benefit Exclusions</u>	<u>Page</u>
Indemnity Medical Benefit Exclusions	35
Prescription Drug Benefit Exclusions	50
Indemnity Dental Benefit Exclusions.....	56
Vision Benefit Exclusions.....	64
Accidental Death and Dismemberment Benefit Exclusions	69
Time Loss Benefit Exclusions	71



Plan Administration

This section explains how the Plans are administered. It applies to all Plan participants and their covered dependents.

PLAN ADMINISTRATION

Coordination of Coverage with Other Plans (Does not apply to the Prescription Drug Benefits)

This Trust coordinates its benefits provided through its indemnity plans with other similar plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable expenses. This provision applies to the Trust's self-funded medical, dental and vision benefits. The Trust does not coordinate prescription drug coverage.

If Both Spouses are Covered Under the Trust's Plans: When a person is covered under this Trust in more than one capacity (either as an employee and as a dependent of another employee, or as a dependent child of more than one employee), coverage of the person in each capacity will be considered separately for purposes of this provision, and this provision will apply separately to the coverage of the person in each capacity as though coverage in one capacity was the primary plan and coverage of the person in the other capacity was the secondary plan.

Where there is dual coverage and a dollar limitation on benefits, an individual will receive benefits for qualified services up to the dollar limitation under both the primary and secondary coverage. Where there is a limit based on a number of visits, however, an individual will receive only benefits for qualified services up to the Plan limit.

DEFINITIONS:

Allowable Expense—Any necessary, reasonable, and customary expense covered, at least in part, by one of the plans of the same type (medical, dental, or vision care).

Plans—The following types of medical, dental, and vision benefits: (a) a governmental program (except Medicaid but including Medicare) other than for a motor vehicle insurance contract; or, (b) group insurance or other coverage for a group of individuals, but not including franchise insurance or student coverage obtained through an educational institution.

This Trust—Medical, dental, and vision benefits described in this Booklet, excluding the Prescription Drug Program.

Effect on Benefits: Benefits otherwise payable under this Trust for allowable expenses during a claim determination period may be reduced if:

1. Benefits are payable under any other plan for the same allowable expenses; and
2. The rules listed in "Order of Benefit Determination" on page 79 provide that benefits payable under the other plan are to be determined before the benefits payable under this Trust.

The reduction will be the amount needed to provide that the sum of payment under this Trust plus benefits payable under the other plan(s) does not exceed 100% of the allowable amount. Each benefit that would be payable in the absence of this section will be reduced

PLAN ADMINISTRATION

proportionately. The total amount paid will be charged against any applicable benefit limit of this Trust.

For this purpose, benefits payable under other plans will include the benefits that would have been paid had claims been made for them. Also, to the extent allowed by law, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

If another plan which is primary under this Trust's coordination of benefit rules limits the available benefits based on the existence of other group health coverage, this Trust will pay its benefits based on what the other plan would have paid if no other group health coverage existed. A determination whether another plan limits coverage based on the existence of other group health coverage shall be determined in the sole discretion of the Board of Trustees of this Trust.

Order of Benefit Determination: Except as described under "Modified Health Care Coverage for Medicare Eligible Participants" on page 80, the benefits payable by a plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a plan that does have such a provision. In all other instances, the order of determination will be:

1. Employee/Dependent: The benefits of a plan that covers the person for whom benefits are claimed as an employee, member, or subscriber (but not a retiree) are determined before the benefits of a plan that covers the person as a dependent.
2. Dependent Child—Parents Not Divorced: When this Trust and another plan cover the same child as a dependent, the benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered one of the parents longer are determined before those of the plan that covered the other parent for a shorter period of time.
3. Dependent Child—Divorced Parents: If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child; then,
 - The plan of the spouse of the parent with custody of the child; and finally,
 - The plan of the parent not having custody of the child.

However, if the specific terms of a legally enforceable court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with

PLAN ADMINISTRATION

respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Employee. The benefit of a plan that covers a person as an Employee who is neither laid off nor retired, or as that Employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired Employee or as that Employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
5. Continuation Coverage. If a person is provided coverage under a federal or state continuation law and is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as the person's dependent) is primary and the continuation coverage is secondary.
6. Longer/Shorter Length of Coverage. If none of the previous rules determine the order of benefits, the benefits of the plan which covered an Employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.
7. As an Active Employee, if you or your covered dependents are eligible for Medicare due to ESRD (End Stage Renal Disease) the Trust will pay primary up to the first 30 months. Medicare becomes primary over this plan after an initial 30-month coordination period and benefits under this plan will become secondary. If you are eligible for Medicare, but are not enrolled in both Medicare Part A and B, this plan will estimate what Medicare would have paid as primary and will only pay secondary based on estimated primary coverage. Therefore, the Trust encourages you to enroll in both Medicare Part A and B coverage.

Benefit Credit Provision: When this Trust is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Trust's payments on the patient's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Trust and the others. This provision does not apply to your Dental Plan.

Modified Health Care Coverage for Medicare Eligible Participants: If the individual is:

- An Employee age 65 or over and this Trust is his/her primary coverage, or
- A dependent spouse age 65 or over of an Employee and this Trust is his/her primary coverage, then coordination with other plan's provisions listed previously will not apply to that person's Medicare coverage. Instead, Medicare will adjust its benefits, as required by law, to take into account benefits payable under this Trust. This provision does not apply to your dental, vision, and prescription drug benefits.

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Workers' Compensation and Third-Party Liability Situations—Advancement of Benefits: If you or a dependent require services or supplies or time loss payments as a result of a sickness or injury that is covered by workers' compensation, or where a claim for workers' compensation coverage has been filed, such charges are not covered by this Trust. See "General Exclusions," number six on page 75.

Similarly, if you or a dependent require services or supplies or time loss payments as a result of a sickness or injury which is, or appears to be, the responsibility of one or more third parties and for which payment is or may be made by a third party, or by one or more insurance companies whose insurance policies have become applicable, such charges are not covered by this Trust. The term "insurance" includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability, homeowner's liability, umbrella liability, and medical payments or PIP coverages, regardless of whether such insurance is maintained by the injured person, by a third party, or by any other person or entity. See "General Exclusions," number seven on page 75.

However, if you or a dependent submit a claim for Trust benefits and there is a contested workers' compensation claim pending, or a third-party claim pending, benefits will be advanced for you or your dependent if you sign the Trust's Agreement to Reimburse form including the following obligations:

- The amount of all Trust benefits advanced will be included in the pending claim;
- The injured person, or his/her attorney, will provide the Trust, upon request, with updates on the status of the claim and the achievement of any recovery; and
- When any recovery is obtained, whether by direct payment or settlement (including a "disputed claim" settlement), or by award, judgment, or in any other way, the injured person or his/her attorney will promptly reimburse the Trust the full amount of all benefits advanced to the date of recovery, less only a deduction representing the Trust's proportionate share of the injured person's reasonable attorney fees and costs (if any).

It will not be necessary for the Trust to file a "lien" in order to obtain reimbursement. The Agreement to Reimburse will apply whether or not liability is admitted by the responsible party or insurance company and whether or not reimbursement of the Trust's benefit payments is mentioned in the payment, settlement documents, or in the award or judgment. The Trust reserves the right to first and full reimbursement out of any recovery obtained by the injured person, regardless of how such recovery has been calculated or is described and regardless of whether the individual has been made whole. The Trust may waive or modify this right, through Trust policy, where the circumstances warrant.

In the event the Trust discovers that it has unknowingly advanced benefits in a workers' compensation or third-party liability situation, but the injured person declines to sign an Agreement to Reimburse, or the Trust has a basis for believing an individual will not observe the terms of an Agreement to Reimburse the Trust will suspend or deny payment of all benefits and

PLAN ADMINISTRATION

assess an overpayment for benefits already paid. Failure to reimburse benefits previously advanced will be considered an unauthorized benefit overpayment.

If an unauthorized benefit payment has occurred, the Trust has the right to deduct the benefit overpayment from any future payments owed to the individual or others claiming eligibility through the same individual. If there is an outstanding unauthorized payment, the Trust, with notice to the individual, may prohibit the individual and any family members from enrolling in a Trust-provided HMO or insured option while the unauthorized benefit payment is outstanding.

To obtain an Agreement to Reimburse form, or for additional information, contact the Trust Administrative Office.

Recovery of Unauthorized Benefit Payments

The Trust provides benefits only pursuant to the written terms of the Trust. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Trust, or if a participant or dependent fails to reimburse advanced benefits in response to an Agreement to reimburse, the profiting individual will be obligated, upon notice from the Trust, to make restitution of the overpayment. If restitution is not made, the Trust will be entitled to bring an action to recover the overpayment from the profiting individual and if misrepresentation is involved from any individual or entity participating in the misrepresentation. In any such action the court may award the Trust its reasonable attorney fees and court costs in addition to the amount of the overpayment.

The Trust will also have the right to deduct the amount of a benefit overpayment from any future benefit payments owed to the individual or others claiming eligibility through the same individual. The Trust has the right to require an individual who has received unauthorized benefits to remain in the indemnity plan until the unauthorized benefits are recovered.

Medical and Dental Consultants

The Board of Trustees has authorized the Trust Administrative Office to refer claims for medical, dental, or prescription drug benefits which involve issues as to medical necessity, the nature, classification, scope or duration of care, and the qualification of providers to outside doctors, dentists, or other professionals for their review and advice, and to follow such advice in the adjudication of the referred claims. In determining the issues presented to them, the outside consultants may rely on their own expertise and on professional standards, procedures, and protocols to which they have access. Medical and dental consultants may also be used to determine usual, customary, and reasonable allowances for covered services.

Any claim denial which incorporates or is based upon medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals procedures.

PLAN ADMINISTRATION

Interpretation of Trust Documents

The Board of Trustees may, in its discretion, adopt administrative rules, policy statements, procedures, or motions all for the purpose of insuring the efficient administration of the Trust and its benefit plans. The Board of Trustees reserves the authority and sole discretion to interpret and apply the provisions of the benefit plans and their administrative rules, policy statements, procedures, or motions.

Claim Filing and Claim Appeal Procedures

To receive benefits through this Trust, you must identify yourself to the provider of service as a Plan participant or dependent, and you must be currently eligible.

In some situations, you may receive services or supplies without having to pay in full, although you may have to make a partial payment such as a deductible, co-payment, or other charge.

In other situations, you must pay for services or supplies at the time you receive them, and then seek reimbursement from the Trust Administrative Office by submitting an itemized bill from the provider. When the claim is processed, any partial payments you owe, such as a deductible, co-payment, or other charge, will be subtracted from the amount reimbursed to you.

In most cases, benefits may be assigned for payment directly to the provider. Most billing forms contain a section to assign payment from the Trust directly to your doctor, hospital, or dentist. If you sign the assignment requesting payment to the provider, payment of the claim will be made directly to the provider. All benefit reimbursements for services billed by a preferred provider will be paid to the provider. You do not need to assign payment.

In all situations, you will be responsible to pay for services or supplies not covered by the Trust or for charges that exceed those allowable under the Trust.

How to File a Claim: The claim filing requirements that normally apply to the various benefits provided by the Trust are outlined below. If a claim involves an accident or a potential third-party liability or workers' compensation claim, the Trust may require additional information from you in order to process your claim.

PLAN ADMINISTRATION

ADMINISTRATOR	HOW TO SUBMIT CLAIMS	SUBMIT CLAIMS TO
HMO or Insured Medical and Dental Options		
See Entity's Plan Booklet	See Entity's Plan Booklet	See Entity's Plan Booklet
Trust Medical and Dental Plans		
Trust	In most cases, providers submit bills for you. If they do not request an itemized statement of services and charges, and a diagnosis. Submit the claim with the Trust's name, participant's ID#, and name of the person receiving services.	The Trust Administrative Office
Prescription Drugs		
Express Scripts	Participating pharmacy retail purchases: no claim form required. Non-participating pharmacy purchases: no benefits are paid. Home delivery pharmacy purchases: no claim form required.	Not applicable
Vision		
Vision Service Plan (VSP)	For VSP providers: No claim form required. Non-VSP providers: Submit an itemized statement of charges, your name, and the participant's ID number.	VSP P.O. Box 385018 Birmingham, AL 35238-5018

PLAN ADMINISTRATION

Life Insurance and AD&D – Employees		
Voya	<p>Submit a certified copy of the death certificate, social security numbers for the deceased and the beneficiary, and a Voya claim form.</p> <p>If the insured died within the previous six months in the U.S. or Canada, the death certificate does not need to be certified.</p> <p>Otherwise, a certified copy of the death certificate is required.</p>	The Trust Administrative Office
Life Coverage – Dependents		
Trust	<p>Submit a certified copy of the death certificate and social security numbers for the deceased and the beneficiary.</p> <p>If the insured died within the previous six months in the U.S. or Canada, the death certificate does not need to be certified.</p> <p>Otherwise, a certified copy of the death certificate is required.</p>	The Trust Administrative Office
Weekly Time Loss Benefits		
Trust	Submit a Statement of Disability Claim form completed by your employer and your doctor and signed by you, and a separate Statement of Disability from your doctor.	The Trust Administrative Office

One-Year Time Limit for Filing Claims: For a claim to officially be considered a claim, you must request that the Trust provide benefits for a specific service or supply in accordance with the Trust's reasonable claims filing procedures as described in this section. Except for urgent claims, which may be submitted orally, claims must be submitted in writing to the proper address. Claims must be submitted within one year from the date of receipt of the service or supply. Failure to submit a claim within this time frame or to request review of any action that has adversely affected you will result in a permanent denial of benefits (unless you can establish to the Trust's satisfaction that it was not possible to file a claim within the one-year period). Different policy requirements exist for claims for life and AD&D benefits.

For any claim, the Trust may require additional information to process claims or meet Trust requirements, including inquiries related to eligibility, the nature of services or supplies provided, coordination of benefits, other insurance, third-party reimbursement requirements, or other Trust provisions. Failure to provide this required information may result in denial of the claim for benefits.

PLAN ADMINISTRATION

Claims Review and Appeals Procedures: If your appeal involves benefits provided by an HMO or insured medical or dental provider, you must contact that entity. Appeals involving vision benefits must be pursued through VSP. See the information on page 65.

In order to receive prompt payment for benefit claims, you must follow the proper claim filing procedures. Claims that are properly filed will be processed in accordance with the following guidelines:

Post-Service Health and Weekly Time Loss Claims: Post-service health claims are properly filed claims for medical, dental, prescription drug, or weekly time loss benefits that are not an urgent care or pre-service health claim as defined below. Under normal circumstances, you will be notified of the benefit determination for a post-service health claim within 30 days of receipt of the claim. If additional information is needed to process the claim, you will be notified within 30 days of receipt of the claim and advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received, or (2) when 45 days have passed since the request for additional information was made. Claims requiring a disability determination will be handled in accordance with the time-lines and requirements for disability claims.

Pre-Service Health Claims: Pre-service health claims are properly filed claims that must be preauthorized to receive full benefits from the Trust. Currently inpatient hospital admissions must be preauthorized.

Under normal circumstances, you will be notified of the benefit determination for a pre-service claim within 15 days of receipt of the claim. If additional information is needed to process the claim, you will be notified within 15 days and advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received, or (2) when 45 days have passed since the request for additional information was made.

If services that require preauthorization have already been provided and the issue is what payment, if any, will be made, the Trust will process the claim as a post-service health claim.

Urgent Care Health Claims: Urgent care claims are claims or requests for services that must be decided more quickly because using the normal time frames for benefit determinations and appeals could seriously jeopardize the health of the individual or expose him or her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed orally or in writing by you, your beneficiary, or a health care provider (physician, osteopath, or licensed nurse practitioner) with knowledge of the patient's medical condition.

PLAN ADMINISTRATION

Under normal circumstances, you will be notified of the benefit determination for an urgent care claim as soon as possible within 72 hours of receipt of the claim. If additional information is needed to process the claim, you will be notified within 24 hours and advised of the specific information required. A benefit determination will then be made no later than 48 hours after the earlier of (1) the date the Trust receives the additional information, or (2) 48 hours have passed since the request for additional information was made.

The Trust will treat a claim as urgent if any physician with knowledge of the patient's medical condition deems the claim to involve urgent care. Otherwise, determinations regarding whether a claim is urgent will be made by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If services that constitute urgent care have already been provided and the issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

Concurrent Care Health Claims: Concurrent care claims are those involving a decision to reduce or terminate an ongoing course of treatment, as well as decisions regarding requests by you to extend a course of treatment beyond what has been approved. You will be notified of any reduction or termination of a previously approved course of treatment prior to the date of the reduction or termination, allowing you sufficient time to appeal and obtain a determination on the appeal before the decision is to take effect.

If an urgent care claim is involved, any request by you to extend the course of treatment beyond the period of time or number of treatments previously approved will be decided as soon as reasonably possible. In any case, you will be notified of the determination within 24 hours of receipt of the request.

Any appeal of a decision involving a concurrent care claim will be treated as either a pre-service, urgent care, or post-service claim appeal, as appropriate under the circumstances.

Life Insurance and AD&D Claims: Life insurance and AD&D claims for employees are processed by Voya. Claims should be filed within 60 days of the loss. For any properly filed claim for life insurance or AD&D benefits, Voya will notify you of its claim determination within 45 days of receipt of the claim, and a written notice of the benefit determination will be sent to you. This time period can be extended by two 30-day periods if necessary, for reasons beyond the control of Voya or the Trust.

Life coverage claims for dependents are paid from general Trust assets and processed by the Trust Administrative Office. Claims for dependent life benefits are to be submitted to the Trust Administrative Office within 60 days of the Dependent's death.

Notice of Denial of Benefits: For all types of claims, a notice of denial of benefits will provide the following information:

- The reason for the denial;

PLAN ADMINISTRATION

- A reference to the plan provision relied on;
- A description of any additional material needed to perfect the claim;
- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request;
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature, or an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request; and
- An explanation of the Trust's appeals procedures.

The denial will be mailed to you or your beneficiary at your last known address. For determinations involving urgent care, this information may be provided orally within the appropriate time frame.

How to Appeal a Benefit Denial: You will have 180 days from the date of denial to appeal an adverse benefit determination, except denials of life insurance and AD&D claims must be filed within 60 days. An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

You, your beneficiary, or an authorized representative must submit an appeal in writing, except that urgent care appeals may be submitted orally, to the Trust Administrative Office or to the entity that made the denial. An appeal must identify:

- The benefit determination involved;
- The reasons for the appeal; and
- Any information you or your authorized representative believes is pertinent.

Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by you (or parent or legal guardian where appropriate) that identifies the representative and authorizes him or her to seek benefits for you. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within 180 days of the denial (or 60 days for life and AD&D claims) or 180 days of the Trust's decision on an appeal will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

Appeals Procedures: The following procedures will be the exclusive procedures available to you or your beneficiary who is dissatisfied with an eligibility determination, benefit denial, partial benefit award, or any other adverse benefit determination by the Trust or its authorized claims payors. Appeals involving benefits provided through an HMO or insurance entity or employee life and Accidental Death and Dismemberment benefits through Voya, must use those entities' appeals procedures. These procedures must be exhausted before you or your beneficiary may file suit under Section 502(a) of ERISA.

PLAN ADMINISTRATION

Information to be Provided on Request: You and/or your authorized representative may, on request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures, or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination.

If a decision is based upon a medical necessity determination, an explanation of that determination and its application to the individual's medical circumstances will also be available upon request.

Review of Appeals: Claim appeals will be reviewed by the Trust's Appeals Committee, which consists of at least one employer and one labor organization Trustee, except for employee life insurance and AD&D claims, which are reviewed by Voya. A decision will be made within the following time limits:

- Post-Service and Weekly Disability Claims—an appeal will be presented to the Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following receipt of the appeal. The Appeals Committee will provide the claimant written notification of its decision within five days of the hearing. Notice for other types of claims is as follows:
- Pre-Service Claim—within 30 days of receipt of appeal;
- Urgent Care—within 72 hours of receipt of appeal if the initial claim is complete when submitted, or an additional 48 hours after receiving additional information if it is necessary to process the claim; and
- Life/AD&D—within 45 days of receipt of appeal, or an additional 45 days if special circumstances require an extension.

The Appeals Committee will review the administrative file that consists of all documents relevant to the claim. They will also review all additional information submitted by or on your or your beneficiary's behalf. The review will be conducted without deference to the initial benefit determination.

If the denial is based on medical judgment, the Appeals Committee will receive a review by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who made the initial benefit determination nor a subordinate of that individual. The Appeals Committee may also have an individual with a different professional license review a matter if he or she is qualified to treat the condition involved.

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In the case of urgent claims, information will be provided to the claimant or authorized representative via telephone, facsimile, or other expedited method.

Issuing a Decision: Following a hearing, the Appeals Committee will provide the claimant written notification of its decision within five days. Where appropriate, the Board of Trustees may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing.

The decision will include:

- The specific reasons for an adverse decision;
- A reference to the plan provision(s) involved;
- A statement that all information relevant to the claim is available free upon request;
- Notification of any internal rule or guideline or protocol relied on (or a statement that such information is available free of charge);
- If the decision was based on a medical judgment, an explanation of the medical judgment applying the terms of the Plan to the claimant's circumstances (or a statement that such information is available free of charge); and
- A Notice of the claimant's rights under Section 502(a) of ERISA.

For life and AD&D claims, if the claim remains denied, you may submit a second appeal to Voya within 180 days. A final decision will be made by a member of Voya Claims Management who was not involved in the previous appeal. If your claim still remains denied and you make an appeal within 180 days, the third appeal will be reviewed by three members of Voya Claims Management who were not involved in your previous appeals.

The Trust provides for no voluntary alternative dispute resolution procedures. If you or your beneficiary remains dissatisfied with the Trust's determination after exhausting the claim appeal procedures, you have the right to pursue a civil action under 29 U.S.C. §1132(a) (i.e., Section 502(a) of ERISA). Such an action must be brought within 12 months of the final adverse benefit determination on the claim.

Claim Appeal Procedures for HMOs or Insured Providers: If you are appealing benefits denied by an HMO or insurer with which the Trust contracts, or life and AD&D benefits through Voya, you should follow the procedures outlined by that organization.

Claim Appeals Involving a Determination of Disability: Any claim involving a determination of disability will be handled in accordance with the Department of Labor disability claim appeal regulations.

PLAN ADMINISTRATION

Exhaustion of Remedies/Limitations on Actions: No legal or equitable action for benefits under this Trust will be brought unless and until the claimant has, in accordance with the foregoing claims and appeals procedures:

- Submitted a written claim for benefits as required;
- Been notified that the claim is denied;
- Filed a written request for review; and
- Been notified in writing of the decision of the Appeals Committee or the organization responsible for determining the type of benefit in question.

No legal or equitable action for benefits under this Trust may be commenced against the Trust more than 12 months after the issuance of the Appeals Committee's written decision or the denial of the requested benefit if no appeal is made.



Summary Plan Description and Other Information

This section provides a summary of information which applies to all Plan participants and their covered dependents.

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

Summary Plan Description

Name of Plan: Western Teamsters Welfare Trust Indemnity Plus Plan.

Name, Address and Telephone Number of Plan Sponsor and Administrator: This Plan is sponsored and administered by a joint labor-management Board of Trustees pursuant to an Agreement and Declaration of Trust. The name, address and telephone number of the Board of Trustees is:

Board of Trustees
Western Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102
(206) 329-4900

Name, Title and Principal Place of Business of Each Trustee: See page 115 of this Booklet.

Identification Numbers:

Employer Identification Number: 91-6033601
Plan Number: 501

Type of Plan: This Plan is a health and welfare plan providing medical, prescription drug, dental, vision, weekly time loss, life, and accidental death and dismemberment benefits.

Type of Administration: This Plan is administered by the Board of Trustees with the assistance of Northwest Administrators, a contract administrative organization. The contact information is listed on page 115 of this Booklet. For general information about the Plan, contact the Trust Administrative Office.

Name and Address of Agent for Service of Legal Process: The agent for service of legal process is:

Western Teamsters Welfare Trust
Administrative Manager
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

In addition, service of legal process on the Plan may be served on any member of the Board of Trustees at the Principal Trust Office or at his or her address listed on page 115.

Source of Contributions—Collective Bargaining Agreements: This Plan is maintained by local unions affiliated with the Teamsters Union and employers who are parties to collective bargaining agreements requiring contributions to the Western Teamsters Welfare Trust. These

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

agreements generally provide that the employers who are parties thereto will make monthly contributions to the Western Teamsters Welfare Trust for the purpose of enabling eligible employees working under such agreements to participate in the Western Teamsters Welfare Trust. The contribution rates and the job classifications covered are specified in such agreements. The Plan is funded by these employer contributions (certain employees whose coverage would otherwise terminate may continue coverage for a limited period of time by making the required self-payments).

A copy of each of the applicable collective bargaining agreements is available for examination, without charge, by participants and beneficiaries, at the Trust Administrative Office. A copy of any of these documents may be obtained by participants and beneficiaries upon written request addressed to the Board of Trustees of the Western Teamsters Welfare Trust, 2323 Eastlake Avenue East, Seattle, Washington 98102. The Trust will make a reasonable charge for providing copies of any documents requested.

Information on whether a particular employer or union is making contributions, and if so, the address of the employer or union, may be obtained by participants and beneficiaries without charge upon written request addressed to the Board of Trustees of the Western Teamsters Welfare Trust, 2323 Eastlake Avenue East, Seattle, Washington 98102.

Eligibility for Benefits: Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes such contributions to the Trust. The eligibility rules that describe the requirements under which employees and their dependents become and remain eligible for benefits under this Plan are set forth on pages 3 to 4 of this Booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits: The rules describing the conditions under which the eligibility of employees and their dependents will terminate are on pages 6 and 7 of this Booklet.

This Booklet also describes circumstances under which benefits may be reduced or denied, including descriptions of applicable limitations and exclusions. See the sections that describe particular benefit coverages as well as the specific and general exclusions.

The Board of Trustees has the authority to modify or terminate the benefits, in whole or in part, should financial circumstances so require.

Claim Appeal Procedures: The procedures for presenting denied claims for review are set forth on pages 88 to 91.

Plan Year: The plan year for this Plan is a 12-month period beginning September 1 and ending the following August 31, and is the fiscal year of the Plan for the purpose of accounting and reporting to the U.S. Department of Labor and other regulatory bodies.

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

Funding Mechanism: The Trustees provide benefits to the extent monies are currently available to pay the costs of such benefits. Benefits are available on a month-to-month basis and are not guaranteed to continue indefinitely.

TYPE OF BENEFIT	TYPE OF FUNDING
Medical	The Indemnity Medical benefits are self-funded.
Prescription Drugs	Indemnity prescription drug benefits are administered by Express Scripts and are self-funded.
Dental	Indemnity dental benefits are self-funded. The Trust offers a dental PPO network through Anthem. The Trust also pays premiums to: <ul style="list-style-type: none">• Kaiser Foundation Health Plan of the Northwest• Liberty Dental Plan
Vision	Vision benefits are self-funded. An administrative service-only fee is paid to Vision Service Plan.
Employee Life and Accidental Death and Dismemberment (AD&D)	Premiums are paid to Voya for employee Life and AD&D benefits.
Dependent Life	Dependent life benefits are self-funded.
Weekly Time Loss Benefits	Weekly Time Loss Benefits are self-funded.

Future of the Plan and Trust Fund: The Trustees provide benefits to the extent that monies are currently available to pay the costs of these benefits. Benefits are not guaranteed to continue indefinitely. Pursuant to the terms of the underlying Trust Agreement, the Trustees are vested with the authority to determine the benefits to be provided, to determine the self-payments required to participate, the conditions under which eligibility is provided and to make changes to the Trust as they may deem necessary, including the termination of the Trust and the benefits provided to Retirees and their dependents.

In the event of termination, the Trustees will:

- Make provision out of the Trust for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination;
- Distribute the balance, if any, of the remaining assets of the Trust in such manner as they determine will carry out the purposes of the Trust, including, but not limited to, the

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

providing of existing benefits on a pro-rata basis or the transfer of such funds to a successor trust having the same or similar purposes for the benefit of employees; and

- Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship.

Upon termination, the Board of Trustees may transfer the remaining Trust assets, or any portion thereof, to the Trustees of any fund established for the purpose of providing substantially the same or greater benefits than those contemplated by this Plan. In no event shall any of the funds revert to or be recoverable by any employee, employer, or union.

Newborns' and Mothers' Health Protection Act of 1996: Group Health plans and health insurance issuers generally may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for you or your 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 or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours if applicable).

ERISA Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants be entitled to the following rights:

Right to Receive Information about Your Plan and Benefits:

- You can examine without charge, at the Principal Trust Office, all documents governing the Plan. This includes insurance contracts 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 (EBSA);
- By submitting a written request to the Trust Administrative Office, you can obtain copies of documents governing the operation of the Plan and an updated summary plan description. The Plan Administrator may charge you a reasonable fee for the copies; and
- You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary financial report to each Plan participant.

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

Right to Continue Group Health Plan Coverage:

You can continue health care coverage for yourself, your spouse, and/or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For more details, see COBRA Continuation Coverage and the documents governing Plan rules for COBRA continuation coverage rights.

Right to Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of this employee benefit plan. These people, called “fiduciaries” of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Right to Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- Know why this was done;
- Obtain copies of documents relating to the decision, without charge; and
- Appeal any denial.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request, in writing, a copy of Plan documents or the latest annual report from the Plan and do not receive copies 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 Plan Administrator’s control.

You may file a suit in state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part.

You may file a suit in a federal court if you disagree with the Plan’s decision (or lack thereof) about whether or not a domestic relations order or a medical child support order is qualified.

You may seek assistance from the U.S. Department of Labor or file suit in a federal court if:

- Plan fiduciaries misuse the Plan’s money; or
- You are discriminated against for asserting your rights.

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The court will decide who should pay court costs and legal fees. If you are successful, the court may order the entity 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).

Your Right to Assistance with Questions:

If you have any questions about this Plan, contact the Trust Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA at (866) 444-EBSA, or by downloading them from the Internal Revenue Service Website at www.irs.gov.

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Pursuant to regulations issued by the federal government, the Western Teamsters Welfare Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. The Trust is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured health information.

This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information. This Notice is also available at the Trust's website: www.nwadmin.com.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment. The Trust 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, to determine benefit responsibility under the Trust's Plan or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating physician to another physician so that the physician may ask for your x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

and services to all of the Trust's participants. Health care operations includes: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

If the Trust discloses protected health information for underwriting purposes, the Trust is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor), or any insurer or HMO with which the Trust contracts, and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative. When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law. In addition, the Trust will disclose your health information where applicable law requires. This includes:

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a. In Connection With Judicial and Administrative Proceedings

The Trust will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.

b. When Legally Required And For Law Enforcement Purposes

The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.

c. To Conduct Public Health and Health Oversight Activities

The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

d. In the Event of a Serious Threat to Health or Safety

The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, 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. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

e. For Specified Government Functions

In certain circumstances, federal regulations require the Trust 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.

f. For Workers Compensation

The Trust may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization. Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or in other limited situations.

Your written authorization will be required for any disclosure of your protected health information for marketing or any disclosure involving direct or indirect remuneration to the Trust.

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Your written authorization will also be required for any sale of your protected health information that will result in remuneration to the Trust.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust 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 Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid by you out-of-pocket and in full.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the labor costs in responding to the request.

Right to Receive Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed above. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust'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 Trust determines the records containing your health information are accurate and complete.

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Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; pursuant to an authorization; or in other limited situations. The Trust will provide 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 Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. In the event that the Trust engages in a fundraising activity, you have the right to opt out of any fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. If this Notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official. To exercise any of these rights related to your health information you should contact:

PRIVACY CONTACT PERSON	PRIVACY OFFICIAL
Paul Sangalang WTWT Account Executive Northwest Administrators, Inc. 2323 Eastlake Avenue E. Seattle, WA 98102 Phone: (206) 568-3685 Email: psangalang@nwadmin.com	Doug Wisman Northwest Administrators, Inc. 2323 Eastlake Avenue E. Seattle, WA 98102 Phone: (206) 753-1066 Email: dwisman@nwadmin.com

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice summarizing its privacy practices and duties. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

EFFECTIVE DATE

This Notice and the rights it describes are effective April 14, 2003, as amended May 24, 2013.

Medicare Part D Notice

Please read this Notice carefully and keep it where you can find it. This Notice contains information about your current prescription drug coverage with the Western Teamsters Welfare Trust ("Trust") and prescription drug coverage available for participants who have enrolled in Medicare Part D. This Notice also informs you where to find additional information to help you make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Trust has determined that the prescription drug coverage it currently offers is, on average for all Plan participants, expected to pay out as much as or more than the standard Medicare prescription drug plan will pay, i.e., it is equivalent on a gross basis to Medicare Part D coverage. The Trust is, therefore, providing creditable prescription drug coverage. Read this Notice carefully—it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. Please note you are not required to enroll in Medicare Part D coverage since the Trust is providing creditable coverage.

Because your existing coverage through the Trust is on average expected to pay out as much as or more than the standard Medicare prescription drug plan, you can keep your coverage through the Trust and not pay extra if you later decide to enroll in Medicare Part D coverage.

Participants can enroll in a Medicare prescription drug plan when they first become eligible and each year from October 15 through December 7. Medicare beneficiaries leaving coverage through the Trust may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

Before you decide to enroll in a Medicare prescription drug plan, you should closely compare your current coverage, including which drugs are covered through the Trust, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Please be

SUMMARY PLAN DESCRIPTION AND OTHER INFORMATION

advised that if you enroll in a Medicare prescription drug plan, you will have to pay an annual premium, an annual deductible, and a percentage of your prescription drug expenses.

You should also know that if you drop or lose your prescription drug coverage through the Trust, and you do not enroll in Medicare prescription drug coverage after your current coverage ends, you may have to pay more to enroll in Medicare prescription drug coverage later. If you go for 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will increase at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you are enrolled in Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll.

For more information about this Notice or your current prescription drug coverage, please contact the Trust Office at (206) 329-4900. You will receive this Notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage or if prescription drug coverage through the Trust changes. You may also request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also obtain additional information about Medicare prescription drug plans from the following:

- www.medicare.gov;
- Your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help; and
- 1-800-MEDICARE (1-800-633-4227); TTY (1-877-486-2048).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

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Other Statutory Notices

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the Plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268

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ALASKA – Medicaid	GEORGIA – Medicaid
<p>The AK Health Insurance Premium Payment Program</p> <p>Website: http://myakhipp.com/</p> <p>Phone: 1-866-251-4861</p> <p>Email: CustomerService@MyAKHIPP.com</p> <p>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>	<p>Website: http://dch.georgia.gov/medicaid</p> <p>- Click on Health Insurance Premium Payment (HIPP)</p> <p>Phone: 404-656-4507</p>
ARKANSAS – Medicaid	INDIANA – Medicaid
<p>Website: http://myarhipp.com/</p> <p>Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Healthy Indiana Plan for low-income adults 19-64</p> <p>Website: http://www.in.gov/fssa/hip/</p> <p>Phone: 1-877-438-4479</p> <p>All other Medicaid</p> <p>Website: http://www.indianamedicaid.com</p> <p>Phone 1-800-403-0864</p>
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
<p>Health First Colorado Website: https://www.healthfirstcolorado.com/</p> <p>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</p> <p>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus</p> <p>CHP+ Customer Service: 1-800-359-1991/ State Relay 711</p>	<p>Website: http://dhs.iowa.gov/hawk-i</p> <p>Phone: 1-800-257-8563</p>
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: http://www.kdheks.gov/hcf/</p> <p>Phone: 1-785-296-3512</p>	<p>Website: https://www.dhhs.nh.gov/ombp/nhhpp/</p> <p>Phone: 603-271-5218</p> <p>Hotline: NH Medicaid Service Center at 1-888-901-4999</p>
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: https://chfs.ky.gov</p> <p>Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 609-631-2392</p> <p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>

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LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

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NEBRASKA - Medicaid	RHODE ISLAND - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA - Medicaid	SOUTH CAROLINA - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	WEST VIRGINIA - Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)
UTAH - Medicaid and CHIP	WISCONSIN - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT- Medicaid	WYOMING - Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA - Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notice Regarding Your Rights under the Women's Health & Cancer Rights Act of 1998:

Pursuant to the Women's Health and Cancer Rights Act of 1998, the Plan covers for eligible Participants, the following procedures and supplies related to a mastectomy:

- Reconstruction of the breast in which the mastectomy has been performed;
- Surgery and reconstruction of the other breast in order to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of the mastectomy, including lymphedemas in a manner determined to be medically appropriate in consultation with the attending Physician and the Participant.

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Nondiscrimination Statement

The Western Teamsters Welfare Trust complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Western Teamsters Welfare Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Western Teamsters Welfare Trust:

- 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 formats, 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 Charlene Lind, Civil Rights Coordinator.

If you believe that the Western Teamsters Welfare Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Charlene Lind
Civil Rights Coordinator
Northwest Administrators
2323 Eastlake Ave. E. Seattle, WA 98102
Phone: 800-872-5439
Fax: 206-726-3209
Email: clind@nwadmin.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Charlene Lind, Civil Rights Coordinator, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 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, DC 20201
Phone: 1-800-868-1019
Fax: 800-537-7697.

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

When calling the Trust office, indicate that you need an interpreter and the language needed and an interpreter will be connected to the call. Below are the 15 most spoken languages, other than English.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-872-5439.

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 1-800-872-5439。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-872-5439.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-872-5439.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-872-5439 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-872-5439:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-872-5439 تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-872-5439.

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。1-800-872-5439 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 1-800-872-5439

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-872-5439 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចុះ ទូរស័ព្ទ 1-800-872-5439

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-872-5439.

ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-872-5439 पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-872-5439.

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Board of Trustees

EMPLOYER TRUSTEES	UNION TRUSTEES
John Coulson 9279 Silver Star Ave. Desert Hot Springs, CA 92240	Bob Paffenroth Teamsters Local 63 379 W. Valley Blvd. Rialto, CA 92376
William R. Davidson 79 S. Riverwalk Dr. Palm Coast, FL 32137	Buck Holliday 841 Old State Road Elk, WA 99009
AJ Phillips 6033 Old South Drive Richmond, KY 40475	Patrick Kelly Teamsters Local 952 140 South Marks Way Orange, CA 92868-2698
Doug Ruygrok Albertsons/ Vons Corporate Office 1421 Manhattan Ave. Fullerton, CA 92831	Walter Maestas Teamsters Local 492 4269 Balloon Park Rd. NE Albuquerque, NM 87109
Tom Walters YRC 6016 Kenneth Oak Way Fair Oaks, CA 95628	Michael Simeone 6210 Salvia St. Arvada, CO 80403

WTWT Trust Administrative Office

The Trust Administrative Office's contact information is:

Northwest Administrators
2323 Eastlake Avenue East
Seattle, WA 98102
(206) 726-3235
Toll Free: (800-872-5439)

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Important Contact Information

If you have questions or need to contact:

Administrative Office	
Trust Administrative Office	Northwest Administrators at 206-726-3235 or www.nwadmin.com
Care Management Program	
For Hospital Utilization Review and Pre-authorization For Medical Case Management	Anthem 800-274-7767
PPO Network	
To locate a preferred provider or a preferred provider directory	Your Trust Administrative Office or online at www.anthem.com/ca if you live in California or www.bluecares.com (go to “Blue Finder” then click on “Doctor Finder”) if you live outside California
Indemnity Medical Claims	
For submission of Indemnity Medical Claims	If you live in California, submit to Payor I.D. 47198 or Anthem BlueCross, P.O. Box 60007, Los Angeles, California 90060. If you live outside California, claims should be submitted to your local BlueCross and/or BlueShield plan.
Prescription Drug Benefit Plan	
To locate a Express Scripts retail pharmacy or Home Delivery Pharmacy Service	Express Scripts 800-711-0927 (800-759-1089 TTY) or www.express-scripts.com

Dental Claims	
Dental Plan Benefits or Claims	Anthem Blue Cross Dental Claims Submission: PO Box 659444 San Antonio, TX 78265
Time Loss, Life and AD&D, and Other Matters	
Time Loss Benefits or Claims Life and AD&D Claims Eligibility ID Cards	Trust Administrative Office
Vision Benefit Plan	
To locate a VSP network doctor For vision benefit information	VSP 800-877-7195 www.vsp.com
Dental PPO Network	
Anthem	800-872-5439 www.anthem.com
Alternate Dental Plans	
Kaiser Foundation Health Plan of Oregon (Oregon and Southwest Washington)	800-813-2000 www.kp.org/nw
LIBERTY Dental Plan	(888) 703-6999 www.libertydentalplan.com