Western Teamsters Welfare Trust
An Employer-Employee Jointly Administered Welfare Trust
225 South Lake Avenue, Suite 1200 • Pasadena, CA 91101-3000 • (800) 872-5439

January 2022

Information Regarding Your New Hire Packet

(Nevada, Arizona, and Utah)

Dear New Hire,

Welcome to the Western Teamsters Welfare Trust. This new hire packet contains the following documents:

- Participant Data Form (PDF)
- Summary Plan Description
- Beneficiary Card
- VSP Brochure Regarding Vision Benefits
- Employee Assistance Program Brochure (Anthem Blue Cross)
- SleepMaster Solutions Notice and Program Information Card
- Return Envelope For Your Convenience

To ensure that you and your dependents are covered under the Trust once eligibility rules have been satisfied, you must complete and submit the following forms <u>in advance</u> to the Trust Administrative Office:

- **<u>Participant Data Form</u> –** Complete the form with your personal information. If you are married and/or have dependents that you wish to be covered by the Trust, you must also include their information.

- **<u>Proof of Dependent Eligibility</u>** – To enroll a dependent child, you must submit a photocopy of your child's birth certificate. If married, you must submit a photocopy of your marriage certificate to enroll your spouse.

All forms must be returned to the Trust Administrative Office:

Western Teamsters Welfare Trust
Attn: Accounting & Eligibility
225 South Lake Ave, Suite 1200
Pasadena, CA 91101

Fax: (626) 463-6048

Failure to submit the above forms in a timely manner to the Administrative Office may result in a delay of claims processing.

If you have any questions about your eligibility and other benefits, please contact the Administrative Office at (800) 872-5439.

PS:sa
Enclosures

Western Teamsters Welfare Trust
ENROLLMENT AND/OR CHANGE PARTICIPANT DATA FORM

ADMINISTRATIVE USE ONLY

Date: _____

Initials: _____

INSTRUCTIONS:

- Use BLUE or BLACK INK and PRINT all information.
- Participant must complete this in FULL.
- If you are updating information only, please check here ❑

RETURN COMPLETED FORM TO:
Northwest Administrators, Inc.
Attn: Accounting & Eligibility
225 South Lake Ave Ste 1200
Pasadena, CA 91101-3019
Fax: (626) 463-6048

PARTICIPANT DATA

_ _ ❑ Male ❑ Female
Social Security Number

Date of Birth

Participant Last Name | First Name | Middle Initial

Address *(Mailing)*

❑ Single
❑ Married
Date Married

❑ Divorced
Date Divorced

City | State | Zip Code

Employer (Company Name) | Date of Hire | Union Local No. | Home Phone Number

ELIGIBLE DEPENDENT DATA

DEFINITION OF ELIGIBLE DEPENDENTS *(List eligible dependents below.)*:
Your spouse; your children who are: less than 26 years old or age 26 or older if incapable of self-support because of mental or physical incapacity beginning prior to age 26. Eligible children are your Natural, Adopted, Step and Eligible Foster Children. See your Plan booklet for a more complete description of eligible dependents.

LIST ELIGIBLE DEPENDENTS AS DEFINED ABOVE.

Last	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with participant? If no, complete next section.
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No

Proof of dependent eligibility may be requested; i.e., birth certificate, guardianship letters, marriage certificate, divorce papers. Use bottom of reverse side to name additional dependents.

IF DEPENDENT(S) DO NOT RESIDE WITH PARTICIPANT, COMPLETE BELOW

Dependent Name | Name of person with whom dependent resides | Participant's relationship to dependent

Address of the above person (mailing) | City, State, Zip

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Address of the above person (mailing) | City, State, Zip

Dependent Name | Name of person with whom dependent resides | Participant's relationship to dependent

Address of the above person (mailing) | City, State, Zip

OTHER INSURANCE DATA

If you or any of your dependents have coverage with any other health care plan (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this trust, please complete this section.

Type of Coverage ❑ Medical ❑ Dental ❑ Vision ❑ Other, i.e., Rx, Chiropractic, Mental Health

Dependent Name	Name of Insurance Company	Name of Insured Person
	Insurance Company Address	SSN of Insured Person
	City, State, Zip Code	Relationship to Dependent
	Effective Date of Coverage	Group or Policy Number

Type of Coverage ❑ Medical ❑ Dental ❑ Vision ❑ Other, i.e., Rx, Chiropractic, Mental Health

Dependent Name	Name of Insurance Company	Name of Insured Person
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	City, State, Zip Code	Relationship to Dependent
	Effective Date of Coverage	Group or Policy Number

DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another health care plan and the natural parents are divorced or separated, you are required to provide the following information.

Name or Parent with Custody (if parents have dual custody, indicate) Birth Date of Other Parent

If divorced, did the court establish financial responsibility for the child(ren)'s health care? ❑ No ❑ Yes, if yes, please specify name and

address of the person with responsibility: ______________________________
Name Address

City State Zip Code Phone Number

ADDITIONAL DEPENDENT DATA

LIST ELIGIBLE DEPENDENTS AS PREVIOUSLY DEFINED

Last	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with participant? If no, provide address
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No
					__ __	Male ❑ Female ❑	❑ Yes ❑ No

FAILURE TO RETURN A PARTICIPANT DATA FORM TO THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

It is a crime to knowingly provide false, incomplete, or misleading information to the Trust Administrative Office for the purpose of defrauding the Trust. Penalties include imprisonment, repayment of all claims paid inappropriately, fines, and denial of insurance benefits. With my signature, I hereby certify that the information provided on this Participant Data Form is true and correct and I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to the Western Teamsters Welfare Trust or its designated agent.

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Participant's Signature Date Signed

WESTERN TEAMSTERS WELFARE TRUST

HEALTH & WELFARE BENEFICIARY DESIGNATION FORM

PLEASE TYPE OR PRINT

Employee Name: _____ Social Security Number:_____ ☐Male ☐ Female

Address: _____

_____ _____ _____ Telephone Number: _____
City State Postal Code

Present Employer: _____

Local Union Number: _____

In the space provided below, please indicate the person or persons you wish to designate as beneficiary. You may designate any person or persons, including your estate as beneficiary. (**Please Print all information**)

☐ I request that any Death Benefits be paid in equal shares to the Beneficiaries I have listed below.

☐ I request that any Death Benefits be paid to the first Beneficiary named below who survives me.

Full Name:_____ Relationship_____ Date of Birth_____

Address_____

Phone Number_____ Social Security Number: _____

Full Name:_____ Relationship_____ Date of Birth_____

Address_____

Phone Number_____ Social Security Number: _____

Full Name:_____ Relationship_____ Date of Birth_____

Address_____

Phone Number_____

I understand that this Beneficiary Designation cancels any prior Beneficiary Designation made by me for this death benefit.

_____ _____
Employee's Signature Date Signed

Witnessed By: _____ _____
Witness Signature Date Signed

Please fill out the above information and mail or personally return to:

Western Teamsters Welfare Trust
Attn: Accounting & Eligibility
225 South Lake Ave, Suite 1200
Pasadena, CA 91101

FAX: (626) 463-6048

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.nwadmin.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-872-5439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	No deductible in-network $1,500 per person / $3,000 family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Home health care, hospice care, and prescription drugs are covered (additional copays may apply) before the overall deductible is met.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $75 for emergency room visits.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	No maximum in-network $4,500 individual / $9,000 family out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care that this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or www.bcbs.com or call **1-800-810-2583** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	50% coinsurance	——————none——————
	Specialist visit	$15 copay	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Benefits for out-of-network laboratory claims limited to $300 per date of service.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Retail: $5.00 copay Mail: $0.00 copay	Not Covered	——————none——————
	Preferred brand drugs	Retail: $10 copay Mail: $25.00 copay	Not Covered	——————none——————
	Non-preferred brand drugs	Retail: $10 copay Mail: $25.00 copay	Not Covered	——————none——————
	Specialty drugs	See above.	Not Covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 copay	50% coinsurance	Limited to $1,000 per day at out-of-network ambulatory surgical centers
	Physician/surgeon fees	No charge	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$75 copay	$75 copay	——————none——————
	Emergency medical transportation	No charge	No charge.	——————none——————
	Urgent care	$35 copay	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	No charge	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	50% coinsurance	——————none——————
	Inpatient services	$250 copay	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$15 copay	50% coinsurance	——————none——————
	Childbirth/delivery professional services	$250 copay	50% coinsurance	——————none——————
	Childbirth/delivery facility services			——————none——————
If you need help recovering or have other special health needs	Home health care	No charge.	50% coinsurance	Up to 60 visits per person per calendar year. Deductible waived for this service.
	Rehabilitation services	$15 copay	50% coinsurance	——————none——————
	Habilitation services	$15 copay	50% coinsurance	——————none——————
	Skilled nursing care	$250 copay	50% coinsurance	Up to 60 days per calendar year.
	Durable medical equipment	No charge	50% coinsurance	Limited $2,500 per calendar year. Also limited to specific devices. Refer to SPD.
	Hospice services	No charge	50% coinsurance	Up to $5,000 for one period of care. Deductible waived for this service.
If your child needs dental or eye care	Children's eye exam	Copay only	Reimbursement up to $27	$15 copay every 12 months.1 exam every 12 months. 1 pair of glasses every 24 months, if needed. Out of network reimbursement up to $48 for bifocal, $58 for trifocal, and $127 for lenticular lenses.
	Children's glasses	Copay only	Reimbursement up to $31 for single lenses	
	Children's dental check-up	15% coinsurance	15% coinsurance	$2,000 maximum per covered person, per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery.
- Infertility treatment.
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Weight loss programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care • Dental Care (Adult)	• Hearing aids • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact the plan at 1-800-872-5439. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Administration Office at 1-800-872-5439 or the U.S. Department of Health and Human Services at 1-877-696-6775.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-872-5439.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-872-5439.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-872-5439.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-872-5439.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *copay*	$15
Hospital *copay*	$250
Other *copay*	$15

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *copay*	$15
Hospital *copay*	$250
Other *copay*	$15

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copay*	$15
Hospital *copay*	$250
Other *copay*	$15

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The plan would be responsible for the other costs of these EXAMPLE covered services.