

Western Teamsters Welfare Trust

BENEFIT HIGHLIGHTS BY ACTIVE OR CASUAL EMPLOYEES

BENEFITS	ACTIVE/CASUAL	WHO CAN BE COVERED
Indemnity Medical	Active and Casual	You and your dependents <i>(if you select an HMO plan, that plan will provide your medical benefits)</i>
Indemnity Prescription Drug	Active and Casual	You and your dependents <i>(if you select an HMO plan, that plan will provide your prescription drug benefits)</i>
Indemnity Mental Health and Chemical Dependency	Active and Casual	You and your dependents <i>(if you select an HMO plan, that plan will provide your mental health and substance abuse benefits)</i>
Indemnity Dental	Active only	You and your dependents <i>(if you reside in an area where an alternative dental plan is available, and you select it, that plan will provide your dental benefits)</i>
Vision Care	Active and Casual	You and your dependents
Life Insurance	Active and Casual	You and your dependents Employee Benefit: \$8,000 (CA employees), \$2,000 (All other employees) Dependent benefit: \$500 (Does not take effect for covered dependents unless they are 14 days of age)
Accidental Death and Dismemberment Insurance	Active and Casual	You and your dependents Employee Benefit only: \$8,000 (CA employees), \$2,000 (All other employees)
Weekly Time Loss	Non-California Active Plan only	Non-California Active Plan employees only: \$150/week subject to FICA Withholding

Enrollment

If you reside in an area where HMO plans or alternate dental plans are available, you may choose between the optional coverage and the indemnity benefits described in below and in the Benefit Booklet, at the time you begin participation in the Trust or during the annual open enrollment period. If you elect an HMO or alternate dental plan, you must remain in that plan

until the next open enrollment. See additional details on page 3 of the Benefit Booklet (Summary Plan Description).

Medical Benefit Highlights – Active and Casual employees

HMO PLAN OPTION

You may select an HMO plan if you live within the service area of an HMO plan listed below. If you select an HMO plan, your medical, prescription drug, and mental health and chemical dependency benefits will be provided through your HMO.

Rules for Electing and Revoking Election of HMO Plan Coverage

If you live within the service area of an HMO plan listed below, you will have an opportunity at the time you become initially eligible and during the annual open enrollment to choose whether to participate in an HMO plan. *If no election is made, you will automatically receive the indemnity medical benefits and other benefits described in this booklet.* If you have previously elected an HMO plan, that election will be honored until you revoke it. Contact your Area Administrative Office for additional information about your HMO plan options. Annual open enrollment is held from July 15th to August 15th each year for a September 1st effective date. During this period you will be sent enrollment materials explaining the options available to you. If you do not receive enrollment materials, contact your Area Administrative Office for additional copies.

HMO PLANS AVAILABLE

The following HMO plans are available:

STATE	HMO PLANS	ACTIVE/CASUAL
Arizona	<ul style="list-style-type: none"> PacifiCare of Arizona 	Active only
California	<ul style="list-style-type: none"> Kaiser Foundation Health Plan PacifiCare of California effective 1/1/04 	Active and Casual Active only
Colorado	<ul style="list-style-type: none"> Kaiser Foundation Health Plan of Colorado PacifiCare of Colorado effective 1/1/04 	Active and Casual Active only
Nevada	<ul style="list-style-type: none"> PacifiCare of Nevada effective 1/1/04 	Active only
New Mexico	<ul style="list-style-type: none"> Lovelace Health Plans Presbyterian Health Plan effective 1/1/04 	Active only Active only
Oregon	<ul style="list-style-type: none"> Kaiser Foundation Health Plan of Oregon (includes Southwest Washington) PacifiCare of Oregon effective 1/1/04 	Active and Casual Active only
Utah	<ul style="list-style-type: none"> Intermountain Health Care effective 9/1/04 	Active only
Washington	<ul style="list-style-type: none"> Group Health Cooperative 	Active only

INDEMNITY MEDICAL BENEFITS SUMMARY

If you did not enroll in an HMO plan, you and your dependents are covered by the medical benefits described below. More detailed explanations can be found in the Benefit Booklet.

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 covered expenses incurred within 90 days from the date of the accident)	\$200 per person; \$600 per family	\$200 per person; \$600 per family
Calendar Year Out-of-Pocket Maximum (does not include deductibles or copays)	\$2,000 per person; \$6,000 per family	\$5,000 per person; \$15,000 per family (Does not include amounts in excess of UCR)
Coinsurance	80% after deductible	60% after deductible
Lifetime Maximum	\$1,000,000 per person	\$1,000,000 per person
How the Plan Works	Eligible expenses provided by PPO providers are paid at 80% until your out-of-pocket expenses (your 20% cost share) for coinsurance adds up to \$2,000 per person or \$6,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year.	Eligible expenses provided by non-PPO providers are paid at 60% until your out-of-pocket expenses (your 40% cost share) for coinsurance adds up to \$5,000 per person or \$15,000 per family during a calendar year. Then the Plan pays 100% of most eligible expenses for the rest of the calendar year.
HOSPITAL AND EMERGENCY ROOM BENEFITS		
Emergency Room Care	You pay \$100 copay per visit, then the Plan pays 80% PPO allowed amount after deductible if due to an illness. Deductible waived for treatment of injury within 48 hours of covered accident or if admitted	You pay \$100 copay per visit, then the Plan pays 60% of UCR after deductible. Deductible waived for treatment of injury within 48 hours of covered accident or if admitted
Utilization Review	Inpatient hospital paid at 70% of PPO allowed amount after deductible when admission is not pre-authorized	Inpatient hospital paid at 50% of UCR after deductible when admission is not pre-authorized
Inpatient Hospital	80% of PPO allowed amount after deductible	60% of UCR after deductible
PHYSICIAN SERVICES		
Inpatient	80% of PPO allowed amount	60% of UCR after deductible

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
	after deductible	
Outpatient	80% of PPO allowed amount after deductible	60% of UCR after deductible
Surgery	80% of PPO allowed amount after deductible	60% of UCR after deductible
Preventive Care (routine outpatient physical exams, immunizations and well-child care)	80% of PPO allowed amount after deductible up to \$500 per person per calendar year	60% of UCR after deductible up to \$500 per person per calendar year
Inpatient Well Newborn Care	80% of PPO allowed amount after deductible for up to 7 days following birth	60% of UCR after deductible for up to 7 days following birth
OTHER PLAN BENEFITS		
Diagnostic X-ray and Lab In or Outpatient	80% of PPO allowed amount after deductible	60% of UCR after deductible
Durable Medical Equipment	80% of PPO allowed amount after deductible	60% of UCR after deductible
Spinal Manipulations (performed by a D.O. or D.C.)	80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO)	60% of UCR after deductible up to 24 treatments per calendar year is a combined PPO / Non-PPO maximum
Physical Therapy (must be a physician referral)	80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO)	60% of UCR after deductible up to 24 treatments per calendar year is a combined PPO / Non-PPO maximum
Occupational Therapy (must be a physician referral)	80% of PPO allowed amount after deductible up to 24 treatments per calendar year (combined PPO / Non-PPO)	60% of UCR after deductible up to 24 treatments per calendar year is a combined PPO / Non-PPO maximum
Acupuncture	80% of PPO allowed amount after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO)	60% of UCR after deductible up to 10 treatments per calendar year is a combined PPO / Non-PPO maximum
Ambulance	80% after deductible	80% of UCR after deductible
Massage Therapy (must be a physician referral)	80% of PPO allowed amount after deductible up to 10 treatments per calendar year (combined PPO / Non-PPO)	60% of UCR after deductible up to 10 treatments per calendar year is a combined PPO / Non-PPO maximum
Jaw Treatment Benefit	80% of PPO allowed amount after 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	60% of UCR after deductible to a \$6,000 lifetime maximum combined PPO / Non-PPO for TMJ or MPD. Regular benefits apply to other jaw conditions and accidental injuries

BENEFITS / SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
Hearing Aids	80% of PPO allowed amount after deductible up to \$500 per ear, (\$1,000 maximum) combined PPO / Non-PPO. Replacement once in a 3-year period	60% of UCR after deductible up to \$500 per ear, (\$1,000 maximum) combined PPO / Non-PPO. Replacement once in a 3-year period
Speech Therapy	80% of PPO allowed amount after deductible up to 60 treatments lifetime maximum combined PPO / Non-PPO	60% of UCR after deductible up to 60 treatments lifetime maximum combined PPO / Non-PPO
ALTERNATIVE TREATMENT SETTINGS, INSTEAD OF HOSPITALIZATION		
Home Health Care	100% of the PPO allowed amount up to 130 visits per person per calendar year. Deductible waived for this service	100% of UCR up to 130 visits per person per calendar year. Deductible waived for this service
Hospice	100% of the PPO allowed amount up to \$5,000 for one period of care. Deductible waived for this service	100% of UCR up to \$5,000 for one period of care. Deductible waived for this service
Skilled Nursing Facility	80% of PPO allowed amount after deductible, up to 120 days per calendar year	60% of UCR charges after deductible, up to 120 days per calendar year

*Benefits for prescription drugs are covered in a separate program administered by Medco Health. Refer to pages **Error! Bookmark not defined.** to **Error! Bookmark not defined.** for a complete description of these benefits.*

*Benefits for mental health and chemical dependency are covered in a separate program administered by Health Management Center. Refer to pages **Error! Bookmark not defined.** to **Error! Bookmark not defined.** for a complete description of these benefits.*

RETAIL PHARMACY SERVICE	
There is no annual deductible for retail prescriptions. You must however, use a participating pharmacy. The percentage of the drug's cost that you are responsible for is called coinsurance.	
Brand-name drugs	You pay 20% coinsurance (\$25 minimum) per prescription
Generic drugs	You pay 20% coinsurance (\$10 minimum) per prescription
A maximum of up to a 34-day supply of covered medication is allowed.	

HOME DELIVERY PHARMACY SERVICE	
There is no annual deductible for mail-order prescriptions.	
Brand-name drugs	You pay \$50 copay per prescription
Generic drugs	No copay per prescription
A maximum of up to a 90-day supply of covered medication is allowed. Standard	

shipping and handling is free.

Vision Benefit Highlights – Active and Casual employees

Your vision care plan, provided and administered by VSP, features a network of over 28,000 private practice doctors nationwide, who 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.

Benefit Copayments

When you select a doctor from the VSP network, your exam, professional services, lenses and frames will be paid in full after you have paid the following copays:

COPAYS	
Exam (every 12 months)	\$15 copay
Lenses and/or frames*	\$25 copay
Contacts (every 12 months)	No copay applies

** If you select a frame that costs more than the Plan allowance, you will be responsible for the additional cost. Lenses are available every 12 months and Frames every 24 months.*

Copays 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.

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'll receive an average 15% discount on the contracted laser center's usual and customary price.

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 WTWT participant's Social Security number. Your doctor and VSP will handle the rest.

3. You pay the doctor a \$15 copay for the exam, and a \$25 copay if you purchase lenses and/or frames.
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-VPS provider reimbursement schedule and copays 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 copay for exam services and a \$25 copay 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
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. For additional information please see the Benefit Booklet.

Dental Benefit Highlights – Active employees only

Active employees may choose a dental plan either at the time you become initially eligible or during the Trust’s annual open enrollment period. (Casuals do not have Dental coverage.) 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:

- Safeguard Dental – California and Arizona (Safeguard is not accepting new patients in Arizona).
- Kaiser Foundation Health Plan of Oregon – Oregon and Southwest Washington.

Both of these plans are described in separate booklets provided by the alternate dental provider. Contact your Area Administrative Office if you have questions.

INDEMNITY DENTAL PLAN BENEFITS

The dental benefits described in below 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 Western Teamsters Welfare Trust. The Plan reimburses you for covered dental services provided to you or your eligible dependents up to the usual, customary and reasonable allowable amount subject to the following provisions and exclusions. See the Benefit Booklet for details.

PAYMENT LEVELS FOR BENEFITS	
Calendar Year Deductible	\$50 per covered person
Annual Benefit Maximum	\$2,000 per covered person
Preventive Care	85% of UCR
Basic Care	80% of UCR
Major Restorative	50% of UCR

Predetermination of Benefits

If your dental work is likely to cost over \$200, you may ask your dentist to send a treatment plan to your Area Administrative Office before beginning your dental work. This “predetermination of benefits” will allow you to know how much the Plan will pay toward

your dental work, and help you budget for your out-of-pocket dental expenses. The Area Administrative Office will let you and your dentist know ahead of time the estimated amount that will be covered by the Plan.

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. See the Benefit Booklet for details.