

WESTERN TEAMSTERS WELFARE TRUST

HEALTH AND WELFARE PLAN FOR RETIREES

Benefit booklet and summary plan description

Effective September 1, 2004

(Includes Notice of Modifications – March 2006 and
Non-Medicare Prescription Drug Copay changes
effective July 1, 2007)

Dear Retirees and your Family Members:

This booklet describes the Western Teamsters Welfare Trust Health and Welfare Plan for Retirees. It contains the Plan's eligibility rules, a definition of eligible dependents, a detailed description of the benefits provided, the continuation rights available through COBRA, the claims and appeal procedures used by the Plan 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 this Plan are funded by an allocated portion of employer contributions made on behalf of current active employees and by the self-payments required of eligible retirees and dependents. The negotiated contributions and self-payments 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.

This Plan provides a benefit program for Non-Medicare eligible retirees and spouses (i.e. early retirees) and a separate benefit program for Medicare eligible retirees and spouses. Dependent coverage is also provided. Given the value and scope of benefits provided, the rules governing the Plan are extensive and are explained in detail in the following pages. We encourage 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 this 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 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 your Area Administrative Office. You will find a list of the Area Administrative Offices and telephone numbers on page 108.

Sincerely,

Board of Trustees Western Teamsters Welfare Trust

Employer Trustees

John Coulson
Don Emery
A.J. Phillips
Jim Roberts, Co-Chair
William R. Davidson

Union Trustees

Randy Cammack
Justin "Buck" Holliday
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Ralph Taurone

Address Questions to Area Offices

All questions about Plan participation, eligibility for benefits, the nature and amount of benefits, or with respect to any matter of Trust Fund or Benefit Plan administration should be referred to your Area Administrative Office. Only the Board of Trustees, the Principal Trust Office, and the Area Administrative Offices are 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 information about the Plan.

Special Notice to Employees Considering Retirement

If you are an active employee considering retirement, please note that when you retire you must make separate application for coverage under this Plan. An application should be submitted before you retire and, in any event, must be submitted no later than 60 days following your retirement date. See page 4 for additional information.

Casual employees are not eligible for benefits under the Western Teamsters Welfare Trust Retirees Plan unless you meet the Retirees Plan eligibility requirements as an Active Regular employee. For a full description of the WTWT Retirees Plan eligibility rules, see page 2 or call the Area Administrative Office.

Future Amendments

This Plan Booklet and Summary Plan Description is complete and up-to-date as of September 1, 2004. Future amendments will be published in the form of inserts which you should keep in the pocket on the inside of the back cover. They may also be included at the end of the plan booklet, as an Addendum, when provided electronically.

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Summary of Benefits Available

BENEFITS DESCRIBED IN THIS BOOKLET

The Retirees Plan provides a benefit program for Non-Medicare eligible retirees (i.e. early retirees) and their dependents, and a separate benefit program for Medicare eligible retirees and their dependents. The benefits provided under these programs are listed below.

BENEFITS	MEDICARE/ NON-MEDICARE	WHO CAN BE COVERED
Indemnity Medical	Medicare and Non-Medicare	You and your dependents <i>(If you select an HMO plan, that plan will provide your medical benefits)</i>
Indemnity Prescription Drug	Medicare and Non-Medicare	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	Non-Medicare	You and your dependents <i>(If you select an HMO plan, that plan will provide your mental health and substance abuse benefits)</i>

Benefits Provided Through Health Maintenance Organization (HMO) Options

If you select an HMO plan, your medical, prescription drug, mental health and chemical dependency benefits will be described in a separate booklet provided by the HMO. Your general eligibility requirements and other information are described in this booklet. The following HMO plans are available:

STATE	HMO PLANS
Arizona	<ul style="list-style-type: none"> PacifiCare of Arizona/Secure Horizons
California	<ul style="list-style-type: none"> Kaiser Foundation Health Plan PacifiCare of California/Secure Horizons
Colorado	<ul style="list-style-type: none"> Kaiser Foundation Health Plan of Colorado PacifiCare of Colorado/Secure Horizons
Nevada	<ul style="list-style-type: none"> PacifiCare of Nevada/Secure Horizons
New Mexico	<ul style="list-style-type: none"> Cimarron Health Plan — Non-Medicare Retirees only Presbyterian Health Plan effective 1/1/04
Oklahoma	<ul style="list-style-type: none"> PacifiCare of Oklahoma/Secure Horizons

STATE	HMO PLANS
Oregon	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Oregon (includes Southwest Washington) • PacifiCare of Oregon/Secure Horizons
Utah	<ul style="list-style-type: none"> • Intermountain Health Care effective 9/1/04 — Non-Medicare Retirees only
Texas	<ul style="list-style-type: none"> • PacifiCare of Texas/Secure Horizons
Washington	<ul style="list-style-type: none"> • Group Health Cooperative • PacifiCare of Washington/Secure Horizons

Enrollment

If you reside in an area where HMO plans are available, you may choose between the optional coverage and the indemnity benefits described in this booklet at the time you begin participation in the Trust or during the annual open enrollment period. If you elect an HMO, you must remain in that plan until the next open enrollment. See additional details on pages 22 and 55.

ELIGIBILITY — MEDICARE AND NON-MEDICARE RETIREES

This section explains the Retiree eligibility and enrollment provisions. It applies to all Plan participants and their dependents.

Application for Retirees Plan Coverage — 60-Day Rule

Your eligibility for a Teamster pension benefit does not include health and welfare benefits. **You must apply separately for this coverage under the Retirees Health and Welfare Plan.** Application forms are available from your Area Administrative Office. It is recommended that you complete and submit an application form prior to your retirement date. You will receive a letter certifying your eligibility to participate in the Retirees Plan once your application has been processed.

An application **must** be submitted:

- Prior to your contemplated retirement date, or
- At the time of your contemplated retirement date, or
- Within 60 days following your pension effective date.

An application submitted later than 60 days following your pension effective date (Western Conference of Teamsters Pension effective date) will not be accepted, and you and your dependents will not qualify for coverage.

Eligibility Under the Retirees Plan Requires:

1. Retirement after employment with a WTWT contributing employer

You have been actively employed with an employer who contributed on your behalf to the Western Teamsters Welfare Trust.

2. No other group coverage

You are not eligible as an active 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.

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 the Western Teamsters Welfare Trust continuously for at least 10 years.

5. Must have earned 60 months of WTWT contributions within prior 84 months (60/84 Rule) or meet the requirements of the Alternative Eligibility Test

You must have been covered by the Western Teamsters Welfare Trust under a collective bargaining agreement accepted by the Trust and have earned 60 months of WTWT 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 WTWT 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 WTWT 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 WTWT contributions (or WTWT contributions combined with contributions to another IBT health and welfare trust which covers the same work classifications as WTWT) within the 300 months immediately preceding your pension effective date.

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

- If your employer has been delinquent in making WTWT 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 12 months.
- If you have worked as a Casual employee under a WTWT collective bargaining agreement, one month of credit will be given for each month you have received coverage based on your casual employment, up to a total of 6 months.
- 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 6 months.

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 Disability Determination 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

To maintain eligibility for the Retirees Plan, you must agree to make monthly Retirees Plan self-payments for yourself and your covered spouse of an amount determined by the Board of Trustees. If you are covered by this Retirees Plan and add a new spouse, you must notify your Area Administrative Office in writing, within 60 days of your marriage. To continue eligibility, self-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 Retirees Plan benefit.

See page 15 for more information on the required self-payments.

Eligible Dependents

Eligible dependents are your:

- Legally married spouse.
- Unmarried children under age 19 who depend on you for support and who are:
 - Your own children, natural or adopted
 - Your stepchildren or foster children
 - Children for whom you are required to provide medical coverage under a Qualified Medical Child Support Order.
- Unmarried children who depend on you for support can continue coverage after they reach age 19 in two situations:
 - A child age 19 or older will be eligible until age 26 if he or she is a full-time student in an educational institution. School vacation, church missions and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.
 - An unmarried eligible dependent child who is physically or mentally incapable of self support at age 19 may continue under the Plan while remaining incapacitated, if your own coverage is in effect. This also applies to a child who, while remaining eligible in this Plan beyond age 19, becomes physically or mentally incapable of self-support.

To continue an eligible child’s health coverage under either of these provisions, you must provide proof of the child’s full-time student status or evidence of the child’s physical or mental incapacity prior to or within 31 days after 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 including children placed in your home pending adoption. Placement for adoption means you assume legal obligation for total or partial support of a child in anticipation of adopting the child.

Foster children — A child related to you by blood or marriage, living in your home, dependent on you for support, and being raised as your own. 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 spouse, dependent on you for support, and being raised as your own.

Dual Coverage Under the Trust

If your spouse is eligible as an employee or retiree under the Western Teamsters Welfare Trust, he or she will be eligible both as an employee/retiree and as a dependent. When both husband and wife are eligible, their children are eligible dependents of both. See pages 84 to 87 for information about coordination of benefits.

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. Retirees or dependents may submit Medical Child Support Orders to their Area Administrative Office for review. Call your Area Administrative Office for additional information.

Updating Participant Data Form

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

Coverage Requirements

WHEN COVERAGE BEGINS

You and your eligible dependents will become covered under this Retirees Plan on your eligibility date if you filed a timely application, are eligible under the rules on pages 4 to 7, and make the required self-payments.

Your initial eligibility date will be the same as the retirement effective date recognized by the Western Conference of Teamsters Pension Trust, or other Teamsters Pension Trust that provides your retirement benefits.

If your retirement effective date is postponed due to a delay in processing your Teamsters pension application (or a related Social Security disability benefit application), you have the following options:

- You may elect to initiate immediate Retirees Plan coverage, at full cost self-payment rates, subject to retroactive adjustment of these payments if and when the pension application is approved, or
- You may elect to waive the commencement of Retirees Plan coverage until you are notified that your pension application has been approved.

Postponement or Suspension of Coverage When Other Benefits Are Available

You or your spouse can suspend or postpone your WTWT Retirees Plan coverage if you have other employment-related health coverage. If you have met the WTWT Retirees Plan eligibility rules and wish to suspend your WTWT Retirees Plan coverage, contact your Area 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 WTWT Retirees Plan while you have suspended WTWT coverage due to other group health coverage.

When you lose your other coverage, contact your Area Administrative Office within 30 days to resume your WTWT Retirees Plan coverage. Your Area 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 WTWT Retirees Plan coverage to resume. They will advise you of your monthly self-payment amount. When the documentation and self-payment is received, your WTWT Retirees Plan coverage will begin or resume.

Deferral of Coverage Until Medicare Eligible

If you or your spouse becomes eligible to participate in the Retirees Plan on or after September 2002, you can make a one-time election that defers Retirees 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 Retirees Plan. Once this deferral election is made, your choice is irrevocable, and you cannot resume participation in the WTWT Retirees Plan until you are Medicare eligible. To select this option, you must submit a deferral request to your Area Administrative office within the same 60-day period you have for electing to initially participate in the Retirees Plan. You must then notify your Area Administrative Office within 30 days of your becoming Medicare eligible.

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.

A newly acquired spouse is eligible from the date of your marriage.

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

WHEN YOUR COVERAGE ENDS

All benefits for you will terminate on the earliest of the following dates:

- The first day, following your return to work as an active employee, you are provided with coverage under any other group health care plan.
- The first day of the month following the month in which there was a suspension or revocation of your monthly pension benefits from the Western Conference of Teamsters Pension Trust or any other Teamster Trust.
- The first day of the month that you failed to make the required monthly self-payment for your coverage.
- Exception: There is a one time reinstatement privilege for Medicare eligible retirees and spouses who drop WTWT coverage to obtain Medicare related coverage outside WTWT and later seek to rejoin the WTWT. See Reinstatement provision on page 15.
- The first day of the month following the month in which this Retirees Plan is terminated.
- The day of your death.

When Your Spouse's Coverage Ends

All benefits for your spouse (if he or she is covered under the Plan) will terminate on the earliest of the following dates:

- The day you, as the retiree, lose your coverage, as described above,
- **Exception:** If your coverage is terminated because of death, your surviving spouse will be covered for the balance of the month in which death occurs. A dependent spouse who is eligible for Medicare on the date of your death may continue coverage under the Retirees Plan for up to three months following the date coverage terminates by making the required monthly self-payments. The amount of monthly self-payments will be equal to the full cost of the Medicare portion of the Retirees Plan as determined at that time. Once the three month surviving spouse benefit has been used the surviving spouse may qualify for COBRA coverage.
- The first day of the month that the required self-payment for spousal coverage was not made,
- **Exception:** There is a one time reinstatement privilege for Medicare eligible retirees and spouses who drop WTWT coverage to obtain Medicare related coverage outside WTWT and later seek to rejoin the WTWT. See Reinstatement provision on page 15.
- The first day of the month following the month in which the retiree and the spouse are divorced.
- The day a dependent enters active military service (except for periods of temporary duty of 31 days or less.)

When Your Dependent's Coverage Ends

All benefits for your dependent children will terminate on the earliest of the following dates:

- As the retiree, the day you lose your coverage, as described above.
- The first day of the month following the month in which a dependent ceases to be an eligible dependent.
- The last day in the month in which your death occurs. If your Medicare eligible surviving spouse continues coverage under the Retirees Plan by making self-payments, coverage may also continue up to three months for your dependent children.
- The day a dependent enters active military service (except for periods of temporary active duty of 31 days or less).

SPECIAL RULE APPLICABLE TO RETIREES WHOSE FORMER EMPLOYER CEASES CONTRIBUTIONS TO THE TRUST

When an employer unit withdraws from participation in the Western Teamsters Welfare Trust, whether at the instance of the employer, the union, or the employees, or because of bankruptcy or business failure, the employer's obligation to pay monthly contributions for active employees comes to an end. There will no longer be any contribution income to support the benefits payable under the Active Employees Plan or this Retirees Plan.

If a retiree's last contributing employer ceases to be a contributing employer, the retiree and any eligible dependents, who are enrolled in this Retirees Plan will no longer share in the allocated portion of employer contributions intended for the Retirees Plan and will be required to make a monthly self-payment equal to the full cost of the benefit program then being provided. Any active employees who may have completed the qualification period required under the eligibility rules of this Retirees Plan, but who have not yet retired, will not be entitled to Trust contributions for coverage.

Employer withdrawals include, but are not limited to, the following situations:

- As a result of collective bargaining negotiations, the employer is no longer contractually obligated to contribute to the Trust.
- The contribution rate or contribution effective date which the employer and union have negotiated is not the standard contribution rate, or the standard contribution effective date recognized by the Western Teamsters Welfare Trust and, after notice, the parties have failed to correct the situation.
- The employer has transferred, consolidated or abandoned the operation covered by the collective bargaining agreement as a result of which the employer has ceased contributing to the Trust.
- Following the sale, merger or consolidation of a contributing employer with another employer, the surviving employer entity declines to contribute to the Trust.
- There has been a decertification or other loss of union representation, resulting in the cessation of an employer's obligation to continue contributions to the Trust.
- There has been a cessation of an employer's obligation to contribute due to the employer's bankruptcy or general business failure.

In any employer withdrawal situation, it is the responsibility of the withdrawing employer to arrange substitute coverage for the retirees and any dependents, and for active employees who have qualified for this Retirees Plan at the time of withdrawal, but have not yet retired. If for any reason the withdrawing employer fails to provide the substitute coverage, the retired employees and the active employees who are qualified, will be allowed to obtain or continue coverage under this Retirees Plan on a month-to-month basis by making a monthly payment equal to the full cost of the health and welfare benefit program then being provided, as this amount is fixed and can be changed from time to time by the Trustees.

For purpose of these provisions, a retiree's "last contributing employer" will be determined as the last employer who made a contribution to the Trust on behalf of the retiree while he or she was an active employee.

ENHANCED RETIREE PRE-FUNDING PROGRAM

The Western Teamsters Welfare Trust has established the WTWT Retiree Pre-Funding Program to help Trust participants pre-fund a portion of their Retirees Plan costs.

How the Program Works

Eligibility

Eligibility to participate in the Retiree Pre-Funding Program is the same as for the WTWT Retirees Plan itself. If you are not eligible for the WTWT Retirees Plan, you will not be eligible for the Retiree Pre-Funding Program. Additionally, retirees who must pay the full cost of the Retirees Plan (such as employees of withdrawn employers and retirees who are already Medicare eligible with a Western Conference of Teamsters Pension effective date before August 1, 2003) will not receive any subsidy from the Retiree Pre-Funding Program

Credits

There are two types of credits under the Retiree Pre-Funding Program. The first is for past service. This credit is based on your service with WTWT participating employers prior to August 1, 2003. All non-Medicare retirees who retired with a Western Conference of Teamsters pension effective date before August 1, 2003 who are eligible for a reduced rate under the WTWT Retirees Plan will receive 10 years of past service credit at \$30 per year (or \$300 per month) from the Retiree Pre-Funding Program. This credit will be applied to the cost of the WTWT Retirees Plan. As noted above, retirees from employers that no longer contribute to WTWT and Medicare eligible retirees will not receive any credit.

If you retired with a Western Conference of Teamsters pension effective date on or after August 1, 2003, you will receive credits both for past service (for example, years worked with WTWT employers before August 1, 2003) and a credit for future service based on years worked with WTWT employers after August 1, 2003. The credit for service before August 1, 2003 ("past service") will be based upon 50% of the employee's years with a WTWT employer to a maximum of 10 years. The value of each year of this service credit will vary depending on if the employee retires before age 57 or after. Employees who retire at age 57 or later up to Medicare age receive a greater credit.

Additionally, if you retire with a Western Conference of Teamsters Pension effective date on or after August 1, 2003 you will receive credits for future service. You will receive one year of future service for each 12 months of contributions made to WTWT on your behalf beginning with August 2003. Again, the value of the service earned on or after August 1, 2003 ("future service") will also vary depending on if you retire before or after age 57. Employees who retire with a Western Conference of Teamsters Pension effective date on or after August 1, 2003 and are 57 or older will receive a greater credit.

What Credits Are Available

The chart below summarizes the credits available to you. If you retire with a Western Conference of Teamsters Pension effective date on or before August 1, 2003, row 1 applies to you. If you retire with a Western Conference of Teamsters Pension effective date after August 1, 2003, rows 2 through 4 apply to you depending on your age when you retire and if you are Medicare eligible.

Retirement date for eligibility and crediting purposes is based on your actual Western Conference of Teamsters Pension effective date.

Row	Retirement Date	Past Service Credit (Years in WTWT On or Before 8/1/03)	Future Service Credit (Years in WTWT After 8/1/03)	Availability of Credit before Medicare Eligibility	Availability of Credit Upon Medicare Eligibility
1	Non-Medicare Retired prior to August 1, 2003	All provided 10 years of past service at \$30 per year or \$300 per month	None	Past service credit	None
2	Retired on or after August 1, 2003 and prior to age 57	50% of past service up to a maximum of 10 years at \$30 per year	All years of future service earned after August 1, 2003 at \$30 per year	All years of past and future service at \$30 per year	All years of past and future service at \$15 per year (Past service subject to 10 year maximum)
3	Retired on or after August 1, 2003 and after reaching age 57	50% of past service up to a maximum of 10 years at \$40 per year	All years of future service earned after August 1, 2003 at \$40 per year	All years of past and future service at \$40 per year	All years of past and future service at \$15 per year (Past service subject to 10 year maximum)
4	Retired on or after August 1, 2003 and after becoming Medicare eligible	50% of past service up to a maximum of 10 years at \$25 per year	All years of future service earned after August 1, 2003 at \$25 per year	None	All years of past and future service at \$25 per year (Past service subject to 10 year maximum)

Retirees who were eligible for Medicare prior to August 1, 2003 will not receive any credits.

Conditions for Receipt and Use of Credits

There are conditions for the receipt and use of credits from the Retiree Pre-Funding Program:

- Credits may be applied only toward the monthly self-payment required by the WTWT Retirees Plan. They may not be used for any other Plan or health coverage.
- If you do not qualify or terminate your participation in the WTWT Retirees Plan, you lose your right to the credit.
- Credits cannot be cashed out and are not subject to assignment, alienation, attachment, and garnishment.
- Credits are not vested. The Trustees reserve the right to change or modify the Retiree Pre-Funding Program and the WTWT Retirees Plan, as required.
- Credits available under the Retiree Pre-Funding Program will not exceed the cost of the WTWT Retirees Plan option in which you participate.
- If your last employer no longer participates in WTWT or leaves WTWT after you retire, you will lose any credit for your years with WTWT prior to August 1, 2003 ("past service").
- Retirees who must pay the full cost of the WTWT Retirees Plan (employees of withdrawn employers) will not receive any credit.
- Retirees who were eligible for Medicare prior to August 1, 2003 will not receive any credits.
- Spouses do not receive any credit unless the cost of the selected coverage option is less than the available subsidy. Then, the rest of the retiree's monthly subsidy can be applied towards the cost of the spouse's coverage.

Retirees Plan Benefits Not Guaranteed

Benefits under the WTWT Retirees Plan Pre-Funding Program are not guaranteed. Benefits are provided on a month-to-month basis, and are financed from a portion of the employer contributions paid for active employees, and from retiree and spouse self-payments. The Trustees reserve the right to modify the credits provided under the program including terminating them if circumstances require.

Monthly Self-Payments Required

Who Must Make Self-Payments

You and your spouse (if he or she is to be covered) must make monthly self-payments to participate in this Retirees Plan. No self-payment is required to cover dependent children at this time. Self-payments are waived for disabled participants in certain situations. See page 16 for more information.

Amount of Self-Payments

The Board of Trustees establishes the required self-payment amounts on an annual basis. Any changes in the self-payment rates are made effective on September first of a given year. The self-payment rates are communicated to you in announcement letters and billings issued by your Area Administrative Office. To confirm the rate applicable to you or your spouse contact your Area Administrative Office.

Factors That Affect Your Self-Payment Rates

Several factors affect the amount of the self-payment that you must pay. These include:

- Any credits available to you under the Enhanced Retiree Pre-Funding Program.
- Whether your former employer has ceased contributing to the Trust.
- Whether you live in an area where an HMO option is available and you elect not to participate in it.
- Whether you and your spouse are Medicare eligible.

Effect of Failure to Make Self-Payments — Self-Payments Must be Continuous

You and your spouse's monthly self-payments must be made on a continuous basis. If you or your spouse stop making self-payments, coverage cannot be reinstated. If you cease making monthly self-payments on your spouse, but continue self-payments on your behalf, your coverage will not be affected.

Reinstatement Provision

A Medicare eligible retiree or spouse participating in the Retirees Plan who, after January 1, 1994, decides to cease self-payments to WTWT in order to obtain Medicare related coverage outside WTWT, may later elect to be reinstated under this Retirees Plan. Only one reinstatement privilege will be extended. As a condition of reinstatement, the participant must have continuity of coverage during the drop-out period. Coverage under this Retirees Plan will be reinstated as of the first of the month following the date on which the participant submits an application for reinstatement accompanied by the required self-payment. The application will describe the continuity of coverage. Your Area Administrative Office will inform you at the time you retire and annually thereafter of your monthly self-payment amount.

Due Date for Self-Payments

Self-payments for you and your spouse are due at your Area Administrative Office before the first of the month for which coverage is provided. You will not be listed as eligible for a month until your self-payment is received. You and your spouse have a 30-day grace period after the first of the month to make the required self-payment.

Example: Your self-payment for the March coverage month is due no later than March first. You and your dependents will not be treated as eligible until your monthly self-payment is received. If your self-payment is not received before March 31, coverage is permanently terminated.

After you are enrolled in the WTWT Retirees Plan, your Area Administrative Office will provide you with a payment coupon book for your required monthly self-payments. You can also arrange to have your self-payments automatically deducted from your checking or savings account through the Sure Pay electronic transfer. If you have questions about how to make your required monthly self-payments, contact your Area Administrative Office.

Special Rule for Certain Disabled Retirees

If a retiree is not yet eligible for Medicare and is receiving Disability Insurance Benefits under the Federal Social Security Act and Disability Retirement Benefits from a Teamsters Pension Trust, no monthly self-payment is required from the retiree until the earlier of:

- The date you become eligible for Medicare (but not to exceed 30 months from the date the disability commenced), or
- The date you are no longer disabled.

Extension of Eligibility – Special Rules

If you are not eligible for Medicare your coverage may be extended beyond the time it would otherwise end in certain situations. Extended coverage under the Plan is available through:

- COBRA Continuation Coverage
- Total Disability — Extension of Medical Benefits for Individual's Disabling Condition Only
- Purchase of an individual insurance policy from an HMO

Eligibility requirements for these provisions are explained below.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (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 your spouse and eligible dependents each have the right to elect to continue Trust health coverages beyond the time coverage would ordinarily have ended under COBRA. The Trust has no other self-payment provision.

Notices to Trust Concerning COBRA

Your Area Administrative Office is responsible for administering COBRA continuation rights for you. All communications must:

- Be made in writing;
- Identify you or the eligible retiree, if different;
- Contain the Trust's name, and must be sent to your Area Administrative Office.

The addresses of the Area Administrative Offices are listed on page 108 of this booklet.

Qualifying Events

Your spouse has the right to elect continuation of coverage if he or she would otherwise lose eligibility due to

- Death of the participating retiree;
- Divorce or legal separation from the participating retiree; or
- The participating retiree 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:

- Death of the participating retiree;
- Divorce or legal separation from the participating retiree;
- The participating retiree becoming eligible for Medicare; or
- The child no longer qualifies 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. Your eligible dependents have the responsibility to inform the Area Administrative Office of a loss of coverage resulting from a divorce, legal separation or a child losing dependent status. **If your eligible dependents have a loss of coverage because of these events, they must notify your Area Administrative Office in writing within 60 days of the date of the above qualifying events.** The written notice must identify the individual who has experienced the qualifying event, the eligible retiree's name, the Trust's name and the qualifying event which occurred. Failure to provide timely notice will result in coverage ending as it normally would under the terms of the Plan.

The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA

Once your Area Administrative Office has received proper notice that a qualifying event has occurred, it will notify your spouse and each of your eligible dependents of their independent rights to elect continuation coverage. A written election must be made in writing within 60 days from the date coverage would otherwise end or 60 days from the date the notification is furnished by the Trust, if 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. The written notice must be sent to the Area Administrative Office. Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

Available Coverage

Your spouse and eligible dependents may continue coverage in the Plan option they had as of your qualifying event. If COBRA is elected, they may change coverage to or from an HMO option available through the Trust during the Trust's annual open enrollment period.

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. If COBRA is elected and a new dependent is acquired through marriage, birth, adoption or placement for adoption, they may be added to the COBRA coverage by providing written notice to the Area Administrative Office within 60 days of acquiring the new dependent. The written notice must identify the retiree, the new dependent, the Trust, the date the new dependent was acquired and be mailed to the Area Administrative Office.

Continuous Coverage Required

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

Cost

A qualified beneficiary must pay the full cost of the continuation coverage, which includes a 2% administration fee. The Trust uses a composite rate which means that you pay the same monthly rate if you are covering one person or an entire family. The cost for the coverages available through the Trust is set annually based on the Trust's plan year (September through August). If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you.

Monthly Self-Payments Required

Your eligible dependents are responsible for the full cost of continuation coverage including the 2% administration fee. 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 Area Administrative Office. Coverage will be terminated if payment is not postmarked or received by the Area Administrative 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 coverage may be made up to 45 days after the date of election. The initial payment must cover all months for which coverage is elected and be retroactive to when Trust coverage ended. If the initial payment is not received or postmarked within 45 days of when coverage ended, the right to continuation coverage will be lost.

Length of Continuation Coverage

Continuation Coverage may continue for a maximum of 36 months. Coverage will end, however, on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Area Administrative Office on a timely basis for the next monthly coverage period;
- Your eligible dependent becomes covered under any other group health plan after the date of COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage);
- Your eligible dependent provide written notice that you wish to terminate your coverage;
- Your eligible dependent becomes entitled to Medicare benefits after the date of COBRA election; or
- The date the Plan terminates.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA 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, 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 first and the Trust will only pay secondary and coordinate with Medicare. 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.

PURCHASE OF AN INDIVIDUAL INSURANCE POLICY FROM AN HMO

If you have elected an optional HMO medical plan, you may have the right to purchase an individual or conversion policy from your HMO. Additionally, your HMO may offer continuation coverage in limited situations when it is not available from the Trust. Contact your HMO for additional information.

INDEMNITY MEDICAL BENEFITS — NON-MEDICARE RETIREES

This section explains the indemnity medical benefits available to retirees and their dependents who are not eligible for Medicare. This section does not apply if you have selected an HMO medical plan.

Important Notice

The Retirees Plan benefit structure for Non-Medicare Retirees is based on information available to the Trustees at the time the Plan was designed. The Trustees may, at their discretion, make benefit, eligibility or funding changes (including changes to your monthly self-payments or other funding considerations) as they deem necessary.

Indemnity Medical Benefits for You and Your Covered Dependents

If you are eligible for Medicare, see Indemnity Medical Benefits — Medicare Retirees beginning on page 54.

HMO PLAN OPTION

You may elect to participate in an HMO plan if you live within the service area of one of the HMO plans listed below and are otherwise eligible for coverage under the Retirees Plan. If you elect 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 one of the HMO plans listed below, you will have an opportunity at the time you become initially eligible, and once each year during open enrollment, to choose whether or not to participate in an HMO plan. If no election is made, you will automatically receive the Indemnity Medical Benefits described in this booklet. If you have previously elected to participate in an HMO plan, that election will be honored until you revoke it. Information about your HMO plan options is available from your Area Administrative Office.

Annual open enrollment is held July 15th to August 15th each year for a September 1st effective date. During this period you will receive materials explaining the options available to you. If you do not receive these materials, contact your Area Administrative Office for additional copies.

Remember, if you live in an area where an HMO option is available and elect not to participate in it, your monthly self-payment amount will be higher.

HMO PLANS AVAILABLE

HMO plans are available in the following states.

STATE	HMO PLANS
Arizona	<ul style="list-style-type: none"> • PacifiCare of Arizona/Secure Horizons
California	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan • PacifiCare of California/Secure Horizons
Colorado	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Colorado • PacifiCare of Colorado/Secure Horizons
Nevada	<ul style="list-style-type: none"> • PacifiCare of Nevada/Secure Horizons
New Mexico	<ul style="list-style-type: none"> • Cimarron Health Plan — Non-Medicare Retirees only • Presbyterian Health Plan effective 1/1/04
Oklahoma	<ul style="list-style-type: none"> • PacifiCare of Oklahoma/Secure Horizons
Oregon	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Oregon (includes Southwest Washington) • PacifiCare of Oregon/Secure Horizons
Utah	<ul style="list-style-type: none"> • Intermountain Health Care effective 9/1/04 — Non-Medicare Retirees only
Texas	<ul style="list-style-type: none"> • PacifiCare of Texas/Secure Horizons
Washington	<ul style="list-style-type: none"> • Group Health Cooperative • PacifiCare of Washington/Secure Horizons

INDEMNITY MEDICAL PLAN OPTION

The indemnity medical benefits described in this booklet are your Plan benefits if you are not eligible for Medicare and did not elect to enroll in an HMO plan. The medical benefits in this section are provided on a self-funded basis by the Western Teamsters Welfare Trust. Your medical benefits are described on pages 24 through 35, your mental health and chemical dependency benefits on pages 36 through 53, and your prescription drug benefits on pages 72 through 79.

NON-MEDICARE RETIREES 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 follow.

PLAN FEATURES	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
Calendar Year Deductible	\$300 per person; \$900 per family	
Calendar Year Out-of-Pocket Maximum <i>(does not include deductible copays)</i>	\$2,000 per person; \$6,000 per family	\$5,000 per person; \$15,000 per family <i>(does not include amounts in excess of UCR)</i>
Coinsurance	80% after deductible	60% after deductible
Lifetime Maximum	\$1,000,000 per person under Trust Medicare and Non-Medicare plans combined	
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 Services <i>(Pre-certification required for inpatient admission)</i>	80% of PPO allowed amount after deductible	60% of UCR charges after deductible
Physician Services Inpatient Visits Outpatient Visits Surgeon's Fees	80% of PPO allowed amount after deductible	60% of UCR charges after deductible
Preventive Care Physical Exams Immunizations Well Child Care	80% of PPO allowed amount after deductible to a maximum of \$500 per person per calendar year	60% of UCR charges to a maximum of \$500 per person, per calendar year, after the deductible
Diagnostic X-ray and Lab	80% of PPO allowed amount after deductible	60% of UCR charges after deductible

PLAN FEATURES	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
Spinal Manipulations Massage Therapy Acupuncture	Plan pays 80% of PPO allowed amount after deductible	Plan pays 60% of UCR charges after deductible
	Limited to 24 spinal manipulations, 10 massage therapy visits and 10 acupuncture visits per calendar year	
Physical and Occupational Therapy	Plan pays 80% of PPO allowed amount after deductible	Plan pays 60% of UCR charges after deductible
	Limited to 24 physical therapy and 24 occupational therapy visits per calendar year	
Ambulance	80% after deductible	80% of UCR after deductible

Benefits for prescription drugs and mental health and chemical dependency are covered in separate programs. Please refer to pages 72 to 79 for a complete description of the prescription drug benefit program administered by Medco Health. Please refer to pages 36 to 53 for a complete description of the mental health and chemical dependency benefit administered by Health Management Center.

Note: All plan maximums include PPO and non-PPO treatment combined. Lifetime maximum includes all amounts paid under the Trust's Medicare and Non-Medicare plans.

Calendar Year Deductible

You must generally pay a deductible each calendar year before the Plan pays benefits. The combined annual deductible for PPO and non-PPO providers is \$300 per person (\$900 per family). To satisfy your deductible, submit charges to your Area Administrative Office, which will apply all eligible expenses until the \$300 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 the next year's deductible. This carryover provision does not apply to out-of-pocket expenses.
- **Common Accident Provision** — If two or more covered family members are injured in the same accident, only one calendar year deductible will be applied to their combined eligible expenses that result from the accident.

ANNUAL OUT-OF-POCKET MAXIMUM FOR COINSURANCE

If You Use a PPO Provider

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 out-of-pocket expenses do not include deductibles or copayments.

If You Use a Non-PPO Provider

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. Eligible out-of-pocket expenses do not include deductibles, copayments or amounts in excess of UCR charges.

Eligible expenses by non-preferred providers for life threatening emergencies and/or life threatening accidental injuries are paid as if provided by a preferred provider.

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.

If You Use Both a PPO Provider and a Non-PPO Provider

The annual out-of-pocket maximum for combined PPO and Non-PPO eligible expenses is limited to \$5,000 per person.

Out of Area Benefits

Retirees and their dependents who reside outside the PPO service area will receive PPO-level benefits, but coverage will be limited to the usual, customary and reasonable (UCR) charge. Out-of-area means covered expenses incurred for services provided by a provider or facility that is over 30 miles from the nearest network provider or network facility. Except for emergencies that the Trust determines to be life-threatening, you must live over 30 miles from the nearest network provider or network facility in order to be eligible for out-of-area benefits that would be paid at 80% of UCR. Any charges in excess of usual, customary and reasonable allowances will be your responsibility.

OVERALL MEDICAL BENEFITS MAXIMUM

The overall medical benefits maximum for each eligible person is \$1,000,000 whether paid in one year or over a period of years. Whenever medical benefits are paid, they are charged against the individual's overall maximum. The lifetime maximum includes all amounts paid under the Trust's Medicare and non-Medicare plans.

Eligible Expenses

You and your eligible dependents are entitled to benefit payments for the medical services and supplies described on pages 27 to 29, 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 Standard Semiprivate Room and Board — If the hospital does not have semiprivate rooms, the eligible charge limit is 90% of the daily charge for its lowest private room rate. Benefits will be paid based on the Plan allowance.

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.

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. Ambulance services will be paid at the preferred level.

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

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

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.

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 surgical dressings; casts, splints, trusses, braces, crutches, blood glucose monitors; rental of wheel chair, hospital bed, or respirator; oxygen and rental of equipment for its administration. The rental cost of durable medical equipment is covered up to the purchase price.

Gastric Bypass and Obesity Surgery — Charges for vertical banded gastroplasty accompanied by gastric banding or gastric segmentation with a Roux-en-Y bypass are covered when approved by the Plan. The patient must be over 18 and meet the criteria used by the Plan to determine coverage which includes: body mass index above 40 for at least five consecutive years, participation for 12 months in a physician supervised diet and exercise program, and the Trust's medical review and approval. Preauthorization is required.

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

Massage Therapy — 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.

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 or your spouse.

Occupational Therapy — By a licensed or registered occupational therapist, the Plan covers charges for medically necessary services to a maximum of 24 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

Organ and Bone Marrow Transplants — Human organ transplants considered medically necessary, appropriate and effective using prevailing standards of community medical practice. Experimental 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, selecting and procuring the organ. If donor expenses are eligible under another plan, this Plan's coordination of benefits provision will apply.

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
- Donor and procurement costs incurred outside the United States unless preapproved by the Plan.

Benefits for all transplants are subject to pre-certification by the Plan's UR company.

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.

Physical Therapy — By a licensed or registered physical therapist, the Plan covers charges for medically necessary services to a maximum of 24 combined PPO/Non-PPO visits per calendar year. A licensed physician or surgeon must prescribe all services.

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. Benefits are covered up to \$500 per person per calendar year after deductible, combined PPO/Non-PPO.

Spinal Manipulations — By a Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) for up to 24 manipulations (combined PPO/Non-PPO providers) per calendar year. You or your doctor may be required to provide supportive materials such as X-rays, chart notes and treatment plans. Treatment for patients under age 15 is subject to review.

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 60 treatments per lifetime combined PPO/Non-PPO. Oral motor training is not considered medical treatment. Preauthorization is recommended.

X-ray and Laboratory Tests and analysis.

CARE MANAGEMENT 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 retirees and their dependents who are covered by the Trust's indemnity medical benefits. They do not apply to anyone covered by an HMO Plan. Your care management programs described on the following pages include:

- Preferred Provider Organization (PPO)
- Hospital Pre-certification Program
- Hospital Discharge Planning and Case Management
- Maternity Options Management (MOM) Program
- Skilled Nursing Facility
- Home Health Care
- Hospice Care.

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) is available to most WTWT participants and their covered dependents. The PPO helps the Trust offer health care at a lower cost. The PPO credentials and contracts with preferred providers to 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 onto 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 the deductible and coinsurance. The PPO will also handle your claim paperwork.

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

PPO Directories

Provider directories are available from your Area Administrative Office, or by calling Beech Street at 877-891-7983. You can also check online at www.beechstreet.com for current PPO facilities and providers including specialists. 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. The Trust does not utilize Beech Street for mental health or substance abuse networks. These types of providers and Trust coverage are provided by HMC. See page 37 for additional information on these benefits provided by the Trust.

Hospital Pre-certification Program

All non-emergency admissions, to PPO or non-PPO hospitals, must be pre-certified before you or a covered dependent enters the hospital. A review determines the length of stay, based on the patient's condition, which will be considered eligible for medical benefits. Each inpatient hospital

admission is reviewed by the Utilization Review company before the patient enters the hospital. If your hospital stay is not pre-certified, benefits are paid at a reduced rate, as follows:

- PPO hospital charges are paid at 70% of eligible expenses after deductible if admission is not pre-certified.
- Non-PPO hospital charges are paid at 50% of eligible expenses after deductible if admission is not pre-certified.

If the admission is an emergency, you must notify the Utilization Review company within 48 hours after admission.

Admissions for childbirth 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.

Admissions for inpatient and alternative psychiatric or chemical dependency treatment must be authorized by HMC. See page 38 for information.

Hospital Discharge Planning and Case Management

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.

Maternity Options Management (MOM) Program

Nurses specializing in maternity training will provide risk assessment, prenatal education and monitoring of the pregnancy with weekly or monthly phone calls to the covered patient.

Skilled Nursing Facility

The Plan provides benefits for a covered skilled nursing confinement starting within 15 days after you or a covered dependent have had a hospital stay of at least three days that was covered by the Plan. 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 60 days maximum, combined PPO/Non-PPO.

Home Health Care

The Plan 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 were not for the 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.).
- 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.
- Medical supplies, laboratory services, drugs and medications prescribed by a doctor.

The Plan pays for up to 130 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 UCR.

Hospice Care

The Plan 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 at 100% of eligible expenses if the hospice services 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 6 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 UCR.

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

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

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

INDEMNITY MEDICAL BENEFIT EXCLUSIONS — NON-MEDICARE RETIREES

Indemnity Medical benefits are not payable for any of the following items. This applies to all medical benefits described on pages 27 to 32.

1. Services or supplies subject to the General Exclusions applicable to all benefits. See pages 80 to 82.
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. Education, training or services for treatment of dyslexia, attention deficit disorders or delays in the development of a child's language, cognitive, motor or social skills.
4. 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).
5. Prescription drugs purchased from a retail pharmacy, mail order pharmacy or hospital pharmacy. 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 72 to 79 for a description of your prescription drug benefits.
6. Vitamins, nutritional or dietary supplements, or over-the-counter drugs or medications (whether or not prescribed by a physician).
7. Orthopedic appliances, shoes or orthotics prescribed primarily for use during participation in sports, recreational or similar activities.
8. Diagnosis and treatment to restore fertility or promote conception such as invitro-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).
9. 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 to charges made for the removal of a malignant tumor, or for dental services received within 12 months after an accident.
10. Treatment of Temporomandibular Joint Disorders (TMJD) or malocclusions involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning of teeth, jaw surgery and orthodontic treatment.
11. 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.
12. Spinal manipulations in excess of 24 treatments per calendar year.

13. Physical therapy services ordered by a physician in excess of 24 treatments per calendar year.
14. Occupational therapy services ordered by a physician in excess of 24 treatments per calendar year.
15. Massage therapy services ordered by a physician in excess of 10 treatments per calendar year.
16. Acupuncture treatments in excess of 10 treatments per calendar year.
17. Pregnancy, or complications resulting from a pregnancy of a covered dependent child including, but not limited to delivery, abortion and miscarriage.
18. Charges for a hearing examination and the cost of a hearing aid device.
19. Long-term storage of blood other than charges associated with bone marrow transplants.
20. Charges, services or supplies prescribed or provided by non-covered providers.
21. 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.
22. 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).
23. 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.
24. Routine office visits, lab tests, X-rays or immunizations in excess of \$500 per person per calendar year.
25. 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.
26. Learning disabilities, marital family problems (including counseling), sexual problems (including counseling), or eating disorders.
27. Education or training, including vocational assistance or counseling, rehabilitation or job training or outreach, lifestyle or fitness programs.
28. Expenses applied to satisfy the annual plan deductible.
29. Expenses in connection with conception, pregnancy or delivery in connection with a surrogacy arrangement.
30. Sex transformations or complications resulting from such surgery, and sexual dysfunction treatment.

31. Expenses in connection with the treatment of mental health or chemical dependency (except as described in “Indemnity Medical Plan Mental Health and Chemical Dependency Benefits — Non-Medicare Retirees on pages 36 to 53).
32. Surgical treatment of obesity or morbid obesity except as described on page 28.

INDEMNITY MEDICAL PLAN MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS — NON-MEDICARE RETIREES

This section explains the mental health and chemical dependency benefits available to retirees and their dependents who are not eligible for Medicare. This section does not apply if you have selected an HMO medical plan.

The Trust's mental health and chemical dependency benefits are provided and administered by Health Management Center, Inc. (HMC).

Indemnity Mental Health and Chemical Dependency Benefits for Non-Medicare Retirees

THE PROGRAM AND HOW IT WORKS

Health Management Center, Inc. (HMC) is an organization specializing in the delivery of managed mental health and chemical dependency care services through a network of licensed professional providers. This includes 24-hour assistance, assessment, referral, outpatient counseling, inpatient and alternate care programs, utilization management and case management.

The HMC provider network includes over 22,000 contracting professional providers (psychiatrists, psychologists, licensed clinical social workers and marriage family child counselors) and approximately 1,100 contracting hospitals and alternate care facilities nationwide. Over 65% of HMC's network exists in the Western United States.

HMC is licensed in the State of California as a specialized health care service plan and regulated by the Department of Corporations. For eligible participants outside the State of California, benefits are provided pursuant to a policy underwritten by the Standard Securities Insurance Company and administered by HMC. For more information about behavioral health care services, call 800-260-6076 and request an Evidence of Coverage (EOC). The EOC provides a detailed explanation in Schedule A of the Appendix.

Mental Health and Chemical Dependency Services

You or your dependents may need mental health or chemical dependency services to deal with mental health disorders and chemical dependency problems. These problems can include:

- Alcohol addiction
- Eating disorders
- Stress
- Drug addiction
- Anxiety
- Depression.

Mental health and chemical dependency covered services consist of outpatient counseling — both individual and group sessions, inpatient acute care hospitalization and alternate care programs. Alternate care programs include day treatment, intensive ambulatory services, chemical dependency rehabilitation programs and partial hospitalization. Services are provided by licensed mental health professionals including psychiatrists, psychologists, licensed clinical social workers and marriage and family therapists. Services received must be medically necessary and appropriate for your condition. HMC will monitor the treatment for mental disorders and chemical dependency to determine medical necessity and the clinically appropriate level of care.

CHOICE OF PHYSICIANS AND PROVIDERS

Participating Outpatient Providers

To maximize your benefits, mental health care or chemical dependency treatment must be authorized by HMC and provided by an HMC network provider. Authorization is available by calling a specially trained HMC staff member at 800-989-8008, 24 hours a day. Calls can also be made to HMC on your behalf by your physician or family member.

If you need to talk to a counselor when you call, you will be connected to one of HMC's staff counselors for immediate assistance. Otherwise HMC will arrange for you to see an HMC contracted provider in your area for assessment. The assessor will help you evaluate your problem and assist you in solving it. The assessment may take one, two or three visits. Assessment sessions are provided at no cost to you and your eligible dependents. If you need help or treatment beyond the assessment sessions, the assessor will refer you to an HMC network provider in your area for treatment. Only medically necessary and clinically appropriate services will be authorized. If you would like to change providers, contact HMC for authorization and the name of another HMC network provider in your area.

If there is not an HMC network provider in your area, you will be referred to an appropriate non-network provider. Call HMC at 800-989-8008 for assistance in locating providers. You must go through the HMC system in order to receive benefits at the higher level.

You do not need to submit claims if you use an HMC network provider. You are only responsible only for any copayment.

If an HMC network provider is terminated, breaks their contract, or is unable to perform their duties, HMC will notify you and the Trust within a reasonable time. Upon termination of an HMC network provider, HMC remains liable for medically necessary and clinically appropriate covered services undertaken by the provider (other than copayments) until the services have been completed. HMC may make reasonable and medically appropriate provisions for the assumption of these services by another HMC network provider.

Every contract between HMC and HMC network providers and facilities states that in the event that HMC fails to pay the involved network provider or network facility, you and your dependents are not responsible for any sums owed by HMC to the provider or facility.

Non-Participating Outpatient Providers

You may also receive medically necessary and clinically appropriate outpatient services from a non-HMC network provider, but you will receive a lower level of benefits. In addition, you will be responsible for any difference between the amount billed by the non-participating provider or facility and the amount paid by HMC. See the Schedule of Benefits on pages 39 to 41.

If you receive care from a non-HMC network provider or receive care without preauthorization from HMC, you must pay for the services and file a claim with HMC that will be considered for reimbursement by this program. Submit claims on a CMS (HCFA)-1500 form and mail to HMC at the following address:

MHN/HMC Claims
P.O. Box 14621
Lexington, KY 40512-4612

Additional instructions and CMS (HCFA)-1500 forms can be found by visiting www.mhn.com (select "member" and then "out-of-network claims").

Inpatient or Alternate Care Treatment

The program provides benefits for inpatient hospitalization and alternate care treatment. You will receive the maximum benefit if you access treatment through HMC and obtain such treatment from an HMC network facility. However, you may elect to receive inpatient hospitalization or alternate care treatment from a non-participating facility provider, but at a lower level of benefits.

Preauthorization from HMC is required for all non-emergency inpatient or alternate care treatment, provided by an HMC network facility or non-HMC network facility. If you do not receive

pre-authorization from HMC prior to entering a hospital or alternate care facility no benefits will be paid under this program. Only medically necessary and clinically appropriate services will be authorized.

To preauthorize an inpatient or alternate care program admission, call HMC at 800-989-8008.

Special Provision Where HMC Network Is Not Available

The HMC nationwide network of contracted providers and facilities can be expanded as a need for services in a particular location arises. Should HMC be unable to refer you to a network provider or facility provider located in your area (within a 30 minute driving distance or 20 mile radius from your home) when you or a dependent need care, you may use the services of a non-HMC network provider or facility. Benefits for these services will be paid as if a network provider or facility had been used, provided the treatment has been pre-authorized by HMC.

This applies only if you call HMC first and give HMC an opportunity to refer you to a network provider or facility in your area (or one who is willing to become a network member for the services that you or your dependent may require). Special situations must be reviewed and approved in advance by HMC.

Emergency Services

Coverage for inpatient hospitalization or alternate care treatment is conditioned on pre-notification and authorization by HMC, except in cases of emergency. In an emergency, HMC will pay for covered services provided by the involved facility for the first 48 hours following the emergency admission.

Coverage for treatment provided after the 48 hours for emergency admissions requires immediate notification to HMC and continuing authorization by HMC of all treatment.

To receive reimbursement for emergency treatment by a non-HMC network facility you must send copies of the emergency report, itemized bill, and your payment receipts to the HMC claims department.

Out-of-Pocket Expenses

Copayments and other out-of-pocket expenses incurred under this program do not apply to deductibles or other out-of-pocket maximums of the Trust Medical Plan.

SCHEDULE OF BENEFITS

	HMC PROVIDER/FACILITY	NON-NETWORK PROVIDER/FACILITY
ALCOHOL OR DRUG ABUSE		
<i>Plan maximums include combined in and out-of-network treatment</i>		
Chemical Dependency Plan Benefits	Plan pays 90% up to \$12,500 maximum per episode, after \$150 deductible per episode.	Plan pays 50% of allowed charges up to \$12,500 maximum per episode, after \$500 deductible per episode.
Inpatient	30 days maximum inpatient treatment (including detox), per episode, up to \$12,500 maximum per episode	
Alternate Care Residential Treatment	<ul style="list-style-type: none"> 2 days of residential treatment equal 1 day of Inpatient treatment 	Non-Network inpatient treatment is limited to 30 inpatient days per year in combination with Network

	HMC PROVIDER/FACILITY	NON-NETWORK PROVIDER/FACILITY
Partial Treatment Intensive Outpatient Treatment	<ul style="list-style-type: none"> • 2 days of partial treatment equal 1 day of Inpatient treatment • 3 days of intensive outpatient treatment equal 1 day of Inpatient treatment 	treatment. Non-Network residential, partial and intensive outpatient treatment(s) are counted as regular inpatient days towards the annual limit.
	<p>Combined network and non-network inpatient, residential treatment, partial treatment and intensive outpatient treatment limited to equivalent of a maximum of 30 inpatient chemical dependency treatment days per episode of treatment.</p> <p>An episode is defined as any continuous course of treatment that focuses on a particular occurrence of a chemical dependency problem. An episode may involve various levels of care or treatment using one or more providers or facilities as a part of medically necessary and clinically appropriate treatment of the presenting problem. Treatment of a relapse of the treated condition within 60 days is considered the same episode.</p> <p>Lifetime maximum: 2 episodes per individual (including detox).</p>	

	HMC PROVIDER/FACILITY	NON-NETWORK PROVIDER/FACILITY
MENTAL HEALTH		
<i>Plan maximums include combined in and out-of-network treatment</i>		
Assessment	Up to 3 individual assessment sessions per individual per calendar year	No Individual Assessment Benefit Covered under Outpatient Benefit
Outpatient	Plan pays \$12.50 per authorized individual or group outpatient treatment session.	Plan pays 50% of allowed charges up to maximum of \$12.50 per session.
	Up to 50 sessions combined in and out-of-network per individual per calendar year.	
Mental Health Inpatient Benefits	Plan pays 100% of authorized inpatient treatment up to 45 days per individual per calendar year.	Plan pays 50% of the allowed charges up to 45 days per individual per calendar year.
Alternate Care		Non-Network inpatient treatment is limited to 45 inpatient days per year in combination with Network treatment. Non-Network residential, partial and intensive outpatient treatment(s) are counted as regular inpatient days towards the annual limit.
Residential Treatment	<ul style="list-style-type: none"> 2 days of residential treatment equal 1 day of inpatient treatment 	
Partial Treatment	<ul style="list-style-type: none"> 2 days of partial treatment equal 1 day of inpatient treatment 	
Intensive Outpatient Treatment	<ul style="list-style-type: none"> 3 days of intensive outpatient treatment equal 1 day of Inpatient treatment 	
	Combined network and non-network inpatient, residential treatment, partial treatment and intensive outpatient treatment limited to equivalent of a maximum of 45 Inpatient Mental Health treatment days per calendar year and total lifetime maximum equivalent of 90 Inpatient Mental Health treatment days.	

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT EXCLUSIONS — NON-MEDICARE RETIREES

Mental health and chemical dependency benefits are not payable for any of the following items:

1. Services or supplies subject to the General Exclusions applicable to all benefits. See pages 80 to 82.
2. Treatment of detoxification in newborns (treatment may be provided by the Trust's medical plan).
3. Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease and Alzheimer's disease.
4. Treatment of mental retardation, other than the initial diagnosis.
5. Treatment of obesity.
6. Court-ordered testing and treatment if not medically necessary.
7. Private hospital rooms and/or private duty nursing, unless medically necessary and authorized by HMC.
8. Ancillary services including vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or educational therapy for learning disabilities or other educational services.
9. All in-network outpatient, inpatient and alternate care services in excess of those authorized by HMC.
10. Broken appointments, except when the participating provider is notified at least 24 hours in advance or in circumstances in which you had no control over missing the appointment and could not notify the participating provider in advance. You may be billed \$30 for each broken appointment. A broken appointment counts as one session.
11. Prescription or non-prescription drugs, except for drugs prescribed by a physician in connection with treatment as an inpatient at a hospital, or as a patient at an alternate care treatment facility. See Prescription Drug Benefits on pages 72 to 79.
12. Inpatient services, treatment, or supplies provided without pre-admission certification from HMC, except in an emergency.
13. Damage to the facility of a participating provider or facility provider caused by you or your dependent. The actual cost may be billed to you or your dependent.
14. Services, treatment or supplies determined to be experimental by the HMC Medical Director according to accepted mental health standards.

15. Health care services, treatment or supplies:

- Provided by Workers' Compensation law or similar legislation
- Obtained through, or required by, any governmental agency or program
- Caused by the conduct or omission of a third party for which you or your dependent has a claim for damages or relief.

16. Services, treatment or supplies for military service disabilities, when treatment is available under governmental health care programs.

17. Services, treatment or supplies primarily for rest, custodial, domiciliary or convalescent care.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT DEFINITIONS

Allowable charges — Fee or charge made by the provider of mental health or chemical dependency services, which may not exceed the prevailing charge in the area for a service of the same nature and duration.

Alternate care treatment — A planned, medical therapeutic program for patients with mental disorders or chemical dependency problems which includes diagnosis, medical care, and treatment when the patient does not require full-time hospitalization, but does need more intensive care than traditional outpatient visits.

Assessor — An HMC network provider selected by HMC for skills in evaluation, diagnosis and referral.

Authorization — A written decision, from the HMC Medical Director or his/her designee, that benefits you or your eligible dependent may receive under this program are payable for certain services.

Chemical dependency — Psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment.

Coordination of benefits — The coordination of benefits payment between two or more payers, on a primary or secondary basis, to avoid duplication of payments.

Copayment — Fee to be collected directly by the HMC network provider or facility from you or your eligible dependent for covered service. The copayment is collected at the time the service is received or as agreed on by you and the HMC network provider or facility.

Covered services — See "Mental Health and Chemical Dependency Services."

Custodial care — Care rendered to a patient who:

- Is mentally or physically disabled and the disability is expected to continue and be prolonged.
- Requires a protected, monitored, or controlled environment whether in an institution or in a home.
- Requires assistance to support the essentials of daily living, and
- Is not under active and specific psychiatric treatment that will reduce the disability enough to enable the patient to function outside the protected, monitored or controlled environment.

A determination that custodial care is required is not precluded by the fact that a patient is under the care of a physician or other provider, and services are being ordered to support and maintain the patient's condition, provide for the patient's comfort or ensure the manageability of the patient.

Dependent — Any person who is a “dependent” of an eligible participant according to the eligibility requirements of the Western Teamsters Welfare Trust. See page 6.

Domiciliary care — Inpatient institutional care provided, not because it is medically necessary, but because the care in the home setting is unavailable, unsuitable, or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

Eligible participant — A participant who is eligible for Western Teamsters Welfare Trust indemnity medical benefits and is not enrolled in an HMO Plan.

Emergency — The sudden onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention and/or mental health and chemical dependency care services, could reasonably result in:

- Serious injury to life or limb
- Permanently placing your health in jeopardy, or
- Causing you serious and permanent dysfunction.

Experimental — Medical care that is investigatory or an unproven procedure or treatment that does not meet generally accepted standards of usual professional medical practice in the general medical community.

Hospital — Any licensed and accredited acute care psychiatric facility or psychiatric unit in a general acute care hospital that provides inpatient care and facilities and services for the diagnosis and treatment of mental disorders.

Inpatient — An eligible participant or dependent who has been admitted to a hospital or alternate care program for bed occupancy to receive necessary mental health or chemical dependency services, with the reasonable expectation that the patient will remain in the institution at least 24 hours.

Medical director — A physician employed by HMC to coordinate and monitor the quality assurance, utilization management, provider and facility service responsibilities for HMC.

Medically necessary service (also “medically necessary” or “medical necessity”) — To be a medically necessary service, a health care service, treatment, or supply must be all of the following:

- Provided for the treatment or diagnosis of a mental disorder or chemical dependency.
- “Appropriate,” meaning that:
 - It is consistent given the symptoms and the diagnosis
 - The type, level and length of the service, supply and setting are needed to provide safe and adequate care and treatment
 - It keeps with generally accepted standards for good medical practice within the organized medical community
 - For a hospital stay, inpatient acute care must be required for treatment or diagnosis, and safe, adequate care cannot be received on an outpatient basis or in a less restrictive

setting.

- When provided by a professional, the professional is licensed or certified according to state and federal law, and the care, treatment, or supply is within the professional's scope of practice as provided by state and federal law and the rules and regulations of supervising professional organization.
- Not for the convenience of your eligible dependent, your health care provider or HMC.
- Provided in an environment where mental health or chemical dependency services are performed at the least restrictive level of care that provides effective treatment.
- Determined to be a medically necessary service by the HMC Quality Assurance/Utilization Management Program.

Mental disorder — A mental or nervous condition that meets the following conditions:

- Clinically significant behavioral or psychological syndrome or pattern.
- Associated with a painful symptom such as distress.
- Impairs a patient's ability to function in one or more major life activities, and
- Listed as an Axis I Disorder (except for V-codes) of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) by the American Psychiatric Association (DSM-IV).

Mental health and chemical dependency services — Services that are medically necessary and clinically appropriate for the treatment of a mental disorder or chemical dependency. Services must be furnished by a professional provider and may include: outpatient individual and group therapy sessions, inpatient hospitalization, day treatment programs, evening programs and intensive outpatient treatment.

Network facility — An HMC contracted hospital or approved alternate care program certified by state and federal laws which provides mental health or chemical dependency services to eligible participants and dependents. Network facility providers sign an agreement with HMC, to accept specific compensation as the total charge, whether paid by HMC or requiring cost-sharing with the eligible participant.

Network provider — A professional mental health care provider (such as licensed clinical social worker, psychologist or psychiatrist) who furnishes mental health or chemical dependency services to eligible participants and dependents. Network providers sign an agreement with HMC, to accept specific compensation as the total charge, whether paid by HMC or requiring cost-sharing with the eligible participant.

Other plan or plan — Any plan which provides full or partial benefits for mental health or chemical dependency services and meets the definition of other similar plans as described in the Coordination of Benefits section of the Medical Plan.

Outpatient — An ambulatory eligible participant receiving covered services who has not been admitted to a hospital or facility.

Payer or group — The Western Teamsters Welfare Trust.

Pre-admission certification — Evaluating and certifying the necessity of a non-emergency admission to a facility provider. Pre-admission certification must be obtained from HMC.

Provider or professional provider — A clinical social worker, marriage family child counselor, psychologist or psychiatrist, who is licensed or certified by state and federal laws to provide mental health or chemical dependency services.

Quality Assurance/Utilization Management Program — A review performed by HMC to determine if the mental health or chemical dependency services provided, or to be provided, meet HMC's standards of quality and are medically necessary and clinically appropriate covered services.

MENTAL HEALTH AND CHEMICAL DEPENDENCY PLAN INFORMATION

Complaints or Grievance Procedures

If you or a dependent have a complaint about services or benefits under this program, you may contact HMC at the address shown on page 46. You will receive a grievance form which you may file with HMC to initiate the grievance resolution procedure. HMC will work with you to resolve the grievance and inform you of its decision. If you are still dissatisfied, you have the right to appeal as described in this Plan booklet.

Coordination of Benefits

If you or your dependents have mental health or chemical dependency coverage under another plan, benefits under this Plan may be coordinated with benefits payable under the other plan. See Coordination of Coverage With Other Plans on pages 84 and 87 of this booklet.

Claiming Mental Health and Chemical Dependency Benefits (Applicable to ERISA Plans)

The Trust's Plans are subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans. All actions described in this section may be taken by you or your authorized representative. HMC may require evidence to verify the authority of your representative to act. You do not need to complete claims forms for Mental Health and Chemical Dependency Services obtained by participating providers. Participating providers will file the claim for you and will be paid directly by HMC. Non-participating provider claims must be submitted within 90 days of services being rendered, in accordance with the terms of the Plan, to the following address:

MHN/HMC Claims
P.O. Box 14621
Lexington, Kentucky 40512-4621

Types of Claims or Requests for Authorization

The requirements for processing claims or requests for authorization depend on the type of claim or request submitted. A claim or request is defined by ERISA in one of the following categories: urgent, pre-service, post-service or concurrent.

Urgent Care Claims

Any claim for medical care or treatment that has not been provided by the date of your claim, where applying standard processes for making care decisions:

- Could seriously jeopardize your life, health or ability to regain maximum function, or
- Would subject you to severe pain that cannot be adequately managed without the care or

treatment that is the subject of the claim. Determinations regarding the severity of pain must be made by a physician with knowledge of your medical condition.

If a physician with knowledge of your medical condition determines that your claim is an urgent care claim, HMC will treat it as such. A health care professional with knowledge of your medical condition may act as your authorized representative for filing and appealing an urgent care claim.

Pre-Service Claims

A request for authorization of medical care or treatment that has not been provided by the date of your claim, that depends in whole or in part on HMC's approval of coverage in advance of obtaining the medical care. Under the Plan, the following services must be preauthorized:

- Mental health inpatient, residential, partial hospitalization and intensive outpatient levels of care
- Chemical dependency detoxification, inpatient rehabilitation, residential, partial hospitalization and intensive outpatient levels of care.

Post-Service Claims

A request for payment or reimbursement of costs for medical care that has already been provided and which is not an urgent care claim or a pre-service claim.

Concurrent Care Claims

A request for authorization of an extension or modification to an approved course of treatment that is already in progress, such as an inpatient hospitalization.

Failure to Follow Procedures in Submitting a Claim

If you fail to follow the proper procedures when filing a pre-service claim or an urgent care claim, HMC will notify you regarding the proper procedures to be followed to complete the claim within:

- 5 days of HMC's receipt of a pre-service claim, or
- 24 hours of HMC's receipt of an urgent care claim.

Insufficient Information

If HMC requires additional information in order to make a determination, you will be notified regarding what information is necessary and given a reasonable amount of time to provide HMC with the requested information.

Notice of Determination

HMC reserves the right to extend the time periods specified below as allowed by law if such extension is necessary due to matters beyond the control of HMC.

Urgent Care Claims

HMC will notify you of its decision (whether or not to pay the claim) as soon as possible, taking into account medical exigencies, but not later than 72 hours after HMC's receipt of your urgent care claim.

If you fail to provide HMC with information sufficient for HMC to decide your claim, you will be notified as soon as possible, but not later than 24 hours after HMC's receipt of the insufficient information. You will have a reasonable amount of time, but not less than 48 hours, to provide the specified information. After you provide the specified information, HMC will provide you with its decision on the claim as soon as possible, but in no later than 48 hours after the earlier of:

- HMC's receipt of the specified information, or
- The end of the period afforded you to provide the specified additional information.

Pre-Service Claims

HMC will notify you of its decision (whether or not to pay the claim) as soon as possible but no later than 15 days after HMC's receipt of your pre-service claim.

HMC reserves the right to a single extension of this 15-day period for an additional 15 days if HMC determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of the time and date by which HMC expects to provide a decision.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information. You will have at least 45 days from the receipt of such notice to provide the specified information.

Post-Service Claims

HMC will notify you of its decision (whether or not to pay the claim) as soon as possible but no later than 30 days after HMC's receipt of your post-service claim. HMC reserves the right to a single extension of this 30-day period, for up to an additional 15 days, if HMC determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension of the time, and the date by which HMC expects to provide a decision.

If the extension is because you failed to submit the information necessary to decide the claim, the notice of extension will describe specifically the required information. You will have at least 45 days from the receipt of such notice to provide the specified information.

Concurrent Care Claims

If HMC has approved an ongoing course of treatment to be provided to you for a period of time or number of treatments, HMC's reduction or termination of the course of treatment (other than by amendment or termination of this Plan) constitutes a denial of your claim. Any reduction or termination by HMC of the approved course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed, is considered an adverse benefit determination. In the event of such a denial, HMC will notify you in sufficient time prior to the reduction or termination in order to allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If you request that the course of treatment be extended beyond the period of time or number of treatments originally approved and such request is an urgent care claim, the request will be decided as soon as possible, taking into account the medical exigencies. HMC will notify you of its benefit determination (whether or not to pay the claim) not later than 24 hours after its receipt of the claim, provided the request for an extension is made at least 24 hours prior to the expiration of the originally approved period of time or number of treatments.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment and the request to extend is an urgent care claim, the claim will be decided according to the urgent care claim timeframes described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service claim or post-service claim timeframes, whichever applies.

If the Claim or Request Is Denied

If the claim or request is denied, delayed or modified due to determination that the services or treatment were not medically necessary or appropriate, either in whole or in part, you will receive a written notice explaining the reasons for the determination including:

- The specific reason or reasons why the claim was denied, delayed or modified.
- Reference to the Plan provisions on which the decision is based.
- If more information is needed, a description of any material necessary to process the claim properly and why the materials are needed.
- A description of HMC's appeal process and any time limits applicable to such procedures.
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal.
- A copy of any internal rule, guideline, protocol or other similar criterion relied on in denying the claim, or a statement that a copy will be provided free upon request.
- If your claim or request was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the HMC plan to the patient's medical circumstances or a statement that such an explanation will be provided free upon request.
- If your claim or request was an urgent care claim, a description of the expedited review process available to you. This initial determination may be explained orally, followed by a written or electronic notice containing this information within 3 days.

Appealing a Denial of Medical Benefits

To appeal a denial of medical benefits, you or your authorized representative must submit a written request for review by HMC. The request must be made within 180 days of the denial and should be accompanied by documents or records in support of the appeal. As part of the review procedure, you or your authorized representative are entitled to:

- Examine and obtain free copies of all health plan documents, records and other information that were used in making the determination.
- Submit written comments, documents, records, and other information relating to the claim or request.
- Obtain information identifying the medical or vocational experts whose advice was obtained on behalf of HMC in connection with the denial of the claim or request. (You are entitled to this information even if HMC did not rely on the information in making its determination).
- Have someone act as your representative in the review procedure, if you wish.

In addition, HMC's review of the appeal must be conducted according to the following rules:

- HMC may not defer to the initial denial of the claim or request. Review of the appeal must be conducted by an HMC Medical Director who is neither the individual who initially denied the claim or request, nor a subordinate of such individual.
- If the denial of the initial claim or request was based in whole or in part on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), an HMC Medical Director must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial decision on the claim or request, nor the subordinate of such an individual.
- If you are appealing the denial of an urgent care claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information may be transmitted between you and HMC by telephone, facsimile or any other available efficient method.

HMC will notify you of the decision on the appeal. Notice will be provided to you:

- As soon as possible, taking into account the medical exigencies, but not later than 72 hours after HMC's receipt of the appeal of an urgent care claim.

- Within a reasonable period appropriate to the medical circumstances, but not later than 30 days after HMC's receipt of the appeal of a pre-service claim.
- Within a reasonable period, but not later than 30 days after HMC's receipt of the appeal of a post-service claim.

If the appeal is denied, you will be provided a written notice containing the following information:

- The specific reason or reasons for the denial of the appeal.
- Reference to the specific HMC plan provision on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of the claim on appeal, that you and HMC may have other voluntary alternative dispute resolution options such as arbitration or mediation, and that you should contact the U.S. Department of Labor to find out what alternatives may be available.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in denying the claim, a copy of that rule, guideline, protocol or criterion, or a statement that a copy will be provided free upon request.
- If the claim or request was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the HMC plan to the patient's medical circumstances or a statement that such an explanation will be provided free upon request.

HMC/MHN Levels of Appeals

You, your authorized representative or provider can appeal a denial of authorization. Contact the HMC/MHN Appeals Unit at 888-426-0028 for information about the appeal process.

HMC/MHN Mandatory Internal Review

If you have an urgent care claim, you, your authorized representative or provider can request an expedited appeal of the denial of authorization for payment by calling HMC at 800-989-8008. An expedited appeal will be arranged and concluded within 72 hours with a different peer reviewer than the one who issued the initial denial. HMC/MHN expedites both concurrent and pre-service appeal requests.

Standard Written Appeal

If you do not have an urgent care claim, you, your authorized representative or provider may submit a standard written appeal within 180 days from the date of the previous adverse determination. Appeal determinations are made within a reasonable time according to the medical circumstances, but no later than 30 days after receipt of the appeal request. A different peer reviewer than the one who issued the initial denial will review the request. Send the appeal request, along with records and any relevant information to:

HMC/MHN
Appeals Unit
1600 Gamos Drive, Suite 300
San Rafael, CA 92647

Voluntary Independent Medical Review

If the decision constitutes a denial of benefits and you have exhausted the HMC/MHN Mandatory Internal Review described above, you may request a voluntary appeal by an independent review organization according to the procedures outlined in the denial letter you received from HMC.

Arbitration

Effective September 1, 2002, you as a WTWT participant, are *not* required to submit disputes about adverse benefit determinations made by HMC/MHN to mandatory binding arbitration. Under ERISA, an adverse benefit determination means a decision by HMC/MHN to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and HMC/MHN may voluntarily agree to arbitrate disputes about adverse benefit determinations at the time the dispute arises.

Civil Actions Under ERISA

Effective September 1, 2002, you have the right to file a civil action under section 502(a) of ERISA if a claim for benefits has not been approved after all mandatory reviews outlined on page 52 have been completed. This means you may voluntarily participate in the Voluntary Independent Medical Review and Arbitration processes previously described. You may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

Questions and Further Information

If you have questions about your covered services, or claims processing, or if you want information about HMC, contact the HMC Member Services Department or write to them at:

Health Management Center, Inc.
7755 Center Avenue, #1000
Huntington Beach, CA 92647
1-800-989-8008

If you have questions about claims processing call 1-800-511-3921.

INDEMNITY MEDICAL BENEFITS — MEDICARE RETIREES

This section explains the medical benefits available to retirees who are eligible for U.S. Medicare and their covered dependents. These benefits do not apply if you have selected an HMO medical plan.

Important Notice

The Retirees Plan benefit structure for Medicare Retirees is based on information available to the Trustees at the time the Plan was designed. Should additional changes be made to Medicare benefits beyond those that were known or contemplated by the Trustees or their advisors, at the time these benefits were designed, the Trustees may, at their discretion, make benefit, eligibility or funding changes (including changes to your monthly self-payments or other funding considerations) as they deem necessary.

Indemnity Medical Benefits for You and Your Covered Dependents

If you are not eligible for Medicare, see Indemnity Medical Benefits — Non-Medicare Retirees beginning on page 21.

HMO PLAN OPTION

You may elect to participate in an HMO plan if you live within the service area of one of the HMO plans listed below and are otherwise eligible for coverage under the Retirees Plan. If you elect 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 one of the HMO plans listed below, you will have an opportunity at the time you become initially eligible, and once each year during open enrollment, to choose whether or not to participate in an HMO plan. If no election is made, you will automatically receive Program One Indemnity Medical Benefits described in this booklet. If you have previously elected to participate in an HMO plan, that election will be honored until you revoke it. Information about your HMO plan options is available from your Area Administrative Office.

Annual open enrollment is held July 15th to August 15th each year for a September 1st effective date. During this period you will receive materials explaining the options available to you. If you do not receive these materials, contact your Area Administrative Office for additional copies.

Please remember that if you live in an area where an HMO option is available and elect not to participate in it, your monthly self-payment amount will be higher.

HMO PLANS AVAILABLE

HMO plans are available in the following states.

STATE	HMO PLANS
Arizona	<ul style="list-style-type: none"> • PacifiCare of Arizona/Secure Horizons
California	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan • PacifiCare of California/Secure Horizons
Colorado	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Colorado • PacifiCare of Colorado/Secure Horizons
Nevada	<ul style="list-style-type: none"> • PacifiCare of Nevada/Secure Horizons
New Mexico	<ul style="list-style-type: none"> • Presbyterian Health Plan effective 1/1/04
Oklahoma	<ul style="list-style-type: none"> • PacifiCare of Oklahoma/Secure Horizons
Oregon	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Oregon (includes Southwest Washington) • PacifiCare of Oregon/Secure Horizons
Texas	<ul style="list-style-type: none"> • PacifiCare of Texas/Secure Horizons
Washington	<ul style="list-style-type: none"> • Group Health Cooperative • PacifiCare of Washington/Secure Horizons

INDEMNITY MEDICAL PLAN OPTION

The indemnity medical benefits described in this booklet are your Plan benefits if you are eligible for Medicare, have enrolled in Medicare parts A and B and did not elect to enroll in an HMO plan. The medical benefits in this section are provided on a self-funded basis by the Western Teamsters Welfare Trust. Your medical benefits are described on pages 57 to 65. Prescription drug benefits are described on pages 72 to 79.

MEDICARE RETIREES 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 follow. If you assigned your Medicare benefits to an HMO, no benefits are available to you or your dependents under this Plan. The Trust indemnity plan will always pay secondary to Medicare. If you are eligible for Medicare Part B, the Trust will Pay benefits as if you have enrolled for Part B benefits whether you have or not.

PLAN FEATURES	PLAN PAYS
Calendar Year Deductible	\$100 per person
Lifetime Maximum	\$1,000,000 with not more than 45 days to be paid for all treatment of mental health and chemical dependency per lifetime
Inpatient Hospital Services (<i>not subject to the deductible</i>)	<ul style="list-style-type: none"> • 70% of Medicare's inpatient deductible in any benefit period • 70% of Medicare's copayment from the 60th day through the 90th day of each benefit period • 70% of eligible hospital expenses after the 90th day of confinement for each benefit period <p>A benefit period starts when a person is admitted to a hospital and ends when a person has not been confined in a hospital or extended care facility for 60 consecutive days</p>
Outpatient Hospital Services	20% of Medicare allowable expense after the plan deductible
Surgery	
Primary Surgeon	20% of Medicare allowable expense after the plan deductible
Assistant Surgeon	20% of Medicare allowable expense after the plan deductible
Anesthesiologist	20% of Medicare allowable expense after the plan deductible
Physician Services	
Hospital Visits	20% of Medicare allowable expense after the plan deductible
Office Visits	20% of Medicare allowable expense after the plan deductible
Outpatient X-ray and Lab	20% of Medicare allowable expense after the plan deductible
Mental Health and Chemical Dependency	Doctor services limited to 20% of reasonable & customary to a maximum of \$12.50 per visit and 50 visits per calendar year

Benefits for prescription drugs are covered in a separate program. Please refer to pages 72 to 79 for a complete description of the prescription drug benefit program administered by Medco Health.

Calendar Year Deductible

You and each of your covered dependents must generally satisfy a deductible each calendar year before the Plan pays benefits. The annual deductible is \$100 per person (inpatient hospital services are not subject to the calendar year deductible). To satisfy your deductible, submit charges to your Area Administrative Office, which will apply all eligible expenses until the \$100 has been reached.

- **Common Accident Provision** — If two or more covered family members are injured in the same accident, only one calendar year deductible will be applied to their combined eligible expenses that result from the accident.

OVERALL MEDICAL BENEFITS MAXIMUM

The overall medical benefits maximum for each eligible person is \$1,000,000 whether paid in one year or over a period of years. Whenever medical benefits are paid, they are charged against the individual's overall maximum. If you are covered under this Retirees Plan and benefits are paid under the Trust's Non-Medicare Retirees Plan, those payments will be applied to your overall medical maximum under this Plan.

There is a separate maximum for mental health benefits of up to 45 days for all treatment paid in one year or over a period of years.

Eligible Expenses

You and your eligible dependents are entitled to benefit payments for the medical services and supplies described on pages 59 to 60, if medically necessary for the treatment of sickness or injury ordered by a physician and are covered by Medicare. Benefit payments are subject to all other Plan provisions including definitions and exclusions.

Inpatient Hospital Expenses

Inpatient facility charges as covered by Medicare.

Covered Expenses In or Out of the Hospital

Acupuncture — Treatment by a licensed or registered acupuncturist if covered by Medicare.

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. Ambulance services will be paid at the preferred level.

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

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

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.

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, blood glucose monitors; rental of wheel chair, hospital bed, or respirator; oxygen and rental of equipment for its administration. The rental cost of durable medical equipment is covered up to the purchase price.

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

Massage Therapy — By a licensed, certified or registered massage therapist if covered by Medicare.

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.

Mental Health and Chemical Dependency — For mental disorders and chemical dependency benefits for doctors services are payable at 20%, after deductible. A total of 50 visits in a calendar year, with a maximum payment up to \$12.50 a visit, will be counted as eligible expenses. These limits do not apply for administering convulsive therapy.

Nursing Care — Private duty nursing by a registered nurse if covered by Medicare.

Obstetrical Care — Hospital and Professional — Pregnancy and childbirth are covered as any other condition for you or your spouse.

Occupational Therapy — By a licensed or registered occupational therapist.

Organ and Bone Marrow Transplants — As determined to be medically necessary and covered by Medicare. Medical expenses of the donor will be eligible according to Medicare's provisions.

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

Physical Therapy — By a licensed or registered physical therapist.

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.

Spinal Manipulations — By a Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) for up to 24 manipulations (combined PPO/Non-PPO providers) per calendar year. You or your doctor may be required to provide supportive materials such as X-rays, chart notes and treatment plans. Treatment for patients under age 15 is subject to review.

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 60 treatments per lifetime combined PPO/Non-PPO. Oral motor training is not considered medical treatment. Preauthorization is recommended.

X-ray and Laboratory Tests and analysis.

CARE MANAGEMENT PROGRAMS

Your care management programs described on the following pages include:

- Skilled Nursing Facility
- Home Health Care
- Hospice Care.

Skilled Nursing Facility

The Plan covers skilled nursing facility care starting within 15 days 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 at 70% of the daily Medicare coinsurance amount after the plan deductible 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.

Home Health Care

The Plan 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 20% 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 were not for the 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.).
- 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.
- Medical supplies, laboratory services, drugs and medications prescribed by a doctor.

The Plan pays for up to 130 home health care visits per person, in a calendar year. 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.

Payments made under this benefit will be applied to your overall medical maximum.

Hospice Care

The Plan 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 services 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 6 months of the terminally ill person's entry or re-entry (after a remission period) in the hospice care program.

The Plan pays 20% of eligible expenses for hospice services for one period of care in the hospice program up to a lifetime maximum of \$5,000. See page 68 for a definition of hospice care programs.

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

Bereavement benefits for a WTWT retiree 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.
- The charges are incurred within three months following the date the terminally ill person dies, and
- Counseling is ordered and received through the hospice care program.

The Plan pays 20% of eligible expenses up to the maximum lifetime bereavement benefit per family of \$200. Payments made under this benefit will be applied to your overall medical maximum.

INDEMNITY MEDICAL BENEFIT EXCLUSIONS — MEDICARE RETIREES

Indemnity Medical benefits are not payable for any of the following items. This applies to all medical benefits described on pages 59 to 62.

1. Any service or supply not covered by Medicare.
2. Services or supplies subject to the General Exclusions applicable to all benefits. See pages 80 to 82.
3. 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.
4. Education, training or services for treatment of dyslexia, attention deficit disorders or delays in the development of a child's language, cognitive, motor or social skills.
5. 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).
6. Prescription drugs purchased from a retail pharmacy, mail order pharmacy or hospital pharmacy. 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 72 to 79 for a description of your prescription drug benefits.
7. Routine or preventive care not necessary to the treatment of any injury or illness including well-child care, immunizations and check-ups.
8. Vitamins, nutritional or dietary supplements, or over-the-counter drugs or medications (whether or not prescribed by a physician).
9. Orthopedic appliances, shoes or orthotics prescribed primarily for use during participation in sports, recreational or similar activities.
10. Diagnosis and treatment to restore fertility or promote conception such as invitro-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).
11. 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 to charges made for the removal of a malignant tumor, or for dental services received within 12 months after an accident.
12. Treatment of Temporomandibular Joint Disorders (TMJD) or malocclusions involving joints or muscles by methods including, but not limited to crowing, wiring or repositioning of teeth, jaw surgery or orthodontic treatment.
13. 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.

14. Spinal manipulations in excess of 24 treatments per calendar year.
15. Physical therapy services in excess of Medicare's allowable.
16. Occupational therapy services in excess of Medicare's allowable.
17. Massage therapy services in excess of Medicare's allowable.
18. Acupuncture treatments in excess of Medicare's allowable.
19. Pregnancy, or complications resulting from a pregnancy of a covered dependent child including, but not limited to delivery, abortion and miscarriage.
20. Charges for a hearing examination and the cost of a hearing aid device.
21. Long-term storage of blood other than charges associated with bone marrow transplants.
22. Charges, services or supplies prescribed or provided by non-covered providers.
23. 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.
24. 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).
25. 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.
26. 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.
27. Learning disabilities, marital family problems (including counseling), sexual problems (including counseling), or eating disorders.
28. Education or training, including vocational assistance or counseling, rehabilitation or job training or outreach, lifestyle or fitness programs.
29. Expenses applied to satisfy the annual plan deductible.
30. Expenses in connection with conception, pregnancy or delivery in connection with a surrogacy arrangement.
31. Sex transformations or complications resulting from such surgery, and sexual dysfunction treatment.
32. Treatment of obesity, or morbid obesity including surgery.

INDEMNITY MEDICAL BENEFITS DEFINITIONS — MEDICARE AND NON-MEDICARE RETIREES

The definitions in this section apply to all indemnity medical benefits described in this booklet.

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.

Area Administrative Office — The Administrative Offices retained by the Trust to provide administrative services. See page 108 for a list of Area Administrative Offices.

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

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

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 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.
- To sustain a patient without attempting to treat an illness or injury.

Deductible — The amount of eligible medical expenses you must pay each calendar year before the Plan 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, including, but not limited to:

- Medical Doctors
- Chiropractors
- Naturopaths
- Physical Therapists
- Occupational Therapists
- Physician's Assistants
- Registered Nurse Practitioners
- Massage Therapists
- Acupuncturists
- 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.
- The least costly alternative that can be safely provided.

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.
- 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 your Area 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.

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, mental health or substance abuse treatment, which are part of the health and welfare plan for retirees. In addition, it does not include any charges for services by a HMO provider if you have elected HMO coverage under the Western Teamsters Welfare 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 massage therapist and prescribed by your physician or surgeon.

Medical Consultant — A qualified medical professional retained by the Trust to give medical advice for determining covered services and supplies, medical necessity, and 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 page 30 for a description of your PPO provider network.

Non-Network or Non-Preferred Provider — A provider who has not contracted with the Trust's PPO Program. See page 30 for a description of your PPO provider 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 covered expenses. The out-of-pocket maximum does not include deductibles, copayments or amounts over UCR.

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.

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 retirees and dependent wives. Expenses in connection with the pregnancy of a dependent child are not covered.

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.
- Malocclusion, overbite or underbite; 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 their occupation.
- Not engaged in any occupation for wage or profit, and
- Under a physician's regular care for that injury or sickness.

A dependent is considered totally disabled when, because of disability, they're 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 Plan 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 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.

INDEMNITY MEDICAL PLAN PRESCRIPTION DRUG BENEFITS — MEDICARE AND NON-MEDICARE* RETIREES

This section explains the retail and mail order prescription drug benefits available to Retirees Plan participants and their covered dependents. These benefits do not apply if you have selected an HMO medical plan.

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

***NON-MEDICARE RETIREES -
PLEASE REVIEW PRESCRIPTION
DRUG COPAY CHANGES
EFFECTIVE 7/1/07 ON LAST PAGE
OF THIS PLAN BOOK DOCUMENT**

Indemnity Prescription Drug Benefits for You* and Your Covered Dependents

***NON-MEDICARE RETIREES - PLEASE REVIEW PRESCRIPTION DRUG COPAY CHANGES EFFECTIVE 7/1/07 (LAST PAGE OF THIS PLAN BOOK DOCUMENT)**

INTRODUCTION

Western Teamsters Welfare Trust has chosen Medco Health 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 Medco Health. If you are enrolled in an HMO medical plan, your prescription drug coverage will be provided by the HMO. Medco Health is the Trust's pharmacy benefit manager with a network of independent and chain pharmacy locations throughout the United States.

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

PLAN BENEFITS (*SEE 7/1/07 COPAY CHANGES FOR NON-MEDICARE RETIREES)

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 40% coinsurance per prescription
Generic drugs	You pay \$8 copay per prescription
A maximum of up to a 34-day supply of covered medication is allowed.	

For example, if a brand-name drug costs \$100, the 40% coinsurance is \$40 and your copay is \$40. If the generic drug costs less than \$8, you only pay the cost of the drug.

Qualified generic drugs will be substituted when permitted by the prescribing physician. If you demand a brand-name drug when your physician allows a qualified generic, you will pay the difference in cost between the brand and the generic, in addition to your cost share.

HOME DELIVERY PHARMACY SERVICE (*SEE NONMEDICARE CHANGES 7/1/07)	
There is no annual deductible for mail-order prescriptions.	
Brand-name drugs	You pay \$30 copay per prescription
Generic drugs	You pay \$15 copay per prescription
A max of up to a 100-day supply of covered medication is allowed. Standard shipping and handling is free.	

Formulary

Your prescription drug benefit includes a formulary, which is a list of generic and brand-name drugs that are preferred by the Plan. 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. Medco Health may remind your doctor when a formulary medication is available for 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 your Area Administrative Office or visit www.medcohealth.com or receive a copy by calling Medco Health at 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 copays. Therefore, you can get the same health benefits at a lower cost. 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 the same high-quality medication, but reduce your out-of-pocket expenses.

Qualified generic drugs will be substituted when permitted by the prescribing physician. If you demand a brand-name drug when your physician allows a qualified generic, you will pay the difference in cost between the brand and the generic, in addition to your cost share.

HOW RETAIL PHARMACY SERVICE WORKS

The retail pharmacy service is most convenient for filling your **short-term prescription needs**. You must use a Medco participating pharmacy to receive Trust benefits. 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 Medco Health network:

- Ask your retail pharmacist.
- Visit www.medcohealth.com and use the online pharmacy locator.
- Call 800-711-0927 (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 retiree.
- Pay your coinsurance or copay (the pharmacist will tell you the amount).

At non-network pharmacies:

If you go to a retail pharmacy that is not part of the Medco Health network, you will not receive benefits from the Trust.

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 1 year (as appropriate). You will pay just one copay 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 Medco Health’s 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.medcohealth.com, or by calling 800-711-0927 (800-759-1089 TTY)
- 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 1 year (if appropriate). Prescriptions may be submitted:

- **By mail** — Send the new prescription(s), along with a *Medco Health Home Delivery Pharmacy Service Order Form* and the appropriate copay, to Medco Health in the return envelope. You can print an order form from the www.medcohealth.com website.
- **By fax** — Ask your doctor to call 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.medcohealth.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 you mail 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.medcohealth.com, or by calling 800-711-0927.

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.medcohealth.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 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 copy to Medco Health in the return envelope.

To make sure that you don't 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.medcohealth.com.

Paying for Your Medication

You may pay your portion of the cost by check, money order, credit card 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 their license:

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

In addition, some prescription drugs require preauthorization by the Plan. Examples are drugs used to treat rheumatoid arthritis, medical Botox and Myobloc.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS — MEDICARE AND NON-MEDICARE RETIREES

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

1. More than a 34-day supply of medication for retail pharmacy prescriptions or a 100-day supply for home delivery service.
2. Services or supplies (including drugs) subject to the General Exclusions applicable to all benefits. See pages 80 and 82.
3. Drugs or medicines procured or procurable without a physician's prescription, including all over-the-counter drugs, (except as described in Covered Prescriptions).
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, 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.
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

WTWT is the primary payer for prescription drug benefits. Benefits for prescription drugs will not be coordinated with other plans.

GENERAL EXCLUSIONS —MEDICARE AND NON-MEDICARE RETIREES

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

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 when the individual is not eligible.
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, (b) must be commonly and customarily recognized as appropriate in the treatment of the patients' 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 services or supplies were 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 may utilize the services of its medical review organizations or their internal guidelines or protocols to determine medical necessity for certain services.
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 (UCR) charge. Usual, customary and reasonable means the maximum amount the Plan 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 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.
5. Any expense or charge for services or supplies which are considered experimental or investigational treatment, as determined by the Trust or its medical consultants. 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:
 - 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 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.
 - Reliable evidence shows the service is not as 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.

- 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 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 Plan's requirements for advancement of benefits. See Advancement of Benefits provision on page 86.
7. Services or supplies obtained 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 observe the Plan's requirements for advancement of benefits. See Advancement of Benefits provision on page 86.
8. Charges for services or supplies 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 plan which states that its benefits are excess to those of any private insurance program or other non-governmental program.
9. Charges for services or supplies required for an injury or illness 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.
11. Charges for any services rendered by you, your spouse or any member of your immediate family.
12. Services or supplies for which a properly completed claim form is not submitted within 12 months of the date the services or supplies are provided or the disability has taken place.

Services or supplies used in these General Exclusions includes 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:

Specific Benefit Exclusions	Page
Indemnity Medical Benefit Exclusions — Non-Medicare Retirees	33
Mental Health and Chemical Dependency Benefit Exclusions — Non-Medicare Retirees ...	42
Indemnity Medical Benefit Exclusions — Medicare Retirees	63
Prescription Drug Benefit Exclusions — Medicare and Non-Medicare Retirees.....	78

PLAN ADMINISTRATION — MEDICARE AND NON-MEDICARE RETIREES

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

COORDINATION OF COVERAGE WITH OTHER PLANS

(Does not apply to the Prescription Drug Benefits)

This Plan coordinates its benefits 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 medical and mental health and chemical dependency benefits.

Who These Provisions Affect

Coordination of benefit provisions apply to Non-Medicare eligible retirees. These provisions also apply when:

- A dependent spouse under the Plan is eligible for Medicare and has other group health coverage as a retiree, or
- A retiree under the Plan is eligible for Medicare and is covered as an eligible spouse of a person who is also a retiree under the Plan.

If Both Spouses are Covered Under WTWT Plans

When a person is covered under this Plan in more than one capacity either as a retiree and as a dependent of another retiree, or as a dependent child of more than one retiree, coverage of the person in each capacity will be considered as a separate plan for purposes of this provision, and this provision will apply separately to the coverage of the person in each capacity as though such coverage were the primary plan and coverage of the person in the other capacity were 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

Plans - The following types of medical and mental health and chemical dependency benefits: (a) coverage under 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 Plan - Medical, mental health and chemical dependency benefits described in this Booklet, excluding Prescription Drug Benefits.

Effect on Benefits

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

- Benefits are payable under any other plan for the same allowable expenses, and
- The rules listed below in "Order of Benefit Determination" provide that benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to provide that the sum of payment under this Plan plus benefits payable under the other plan(s) does not exceed 100% of allowable expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include the benefits that would have been paid if claims had been made for them. Also, 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 the person covered by Medicare does not elect Part B coverage, benefits will be paid at 20% of the UCR allowance for eligible billed Part B charges.

Order of Benefit Determination

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 (that is, other than as a dependent) are determined before the benefits of a plan that covers the person as a dependent.
2. **Dependent Child - Parents Not Divorced.** When this Plan 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 the parent 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 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. **Active/Inactive 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.

Benefit Credit Provision

When this Plan is the secondary plan 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 Plan'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 Plan and the others.

Importance of Enrollment in Medicare Part B

Medicare Part A (hospital charges) is generally automatic when you reach age 65, and requires only completion of a Medicare forms. However, Medicare Part B (physician charges) requires enrollment and monthly premium payments. 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 the person covered by Medicare does not elect Part B coverage, benefits would be paid at 20% of the UCR allowance for eligible, billed Part B charges.

Workers' Compensation and Third Party Liability Situations - Advancement of Benefits

If you or a dependent require services or supplies 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 Plan. See "General Exclusions," number 6 on page 82.

Similarly, if you or a dependent require services or supplies 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 Plan. 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 7 on page 82.

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's 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. 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 Plan, the Trust will suspend or deny payment of all benefits and assess an overpayment for benefits already paid. Failure to reimburse benefits previously advanced will be considered an unauthorized benefit overpayment.

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

RECOVERY OF UNAUTHORIZED BENEFIT PAYMENTS

The Trust provides benefits only pursuant to the written terms of this Plan. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Plan, 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 legal 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 legal 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.

MEDICAL CONSULTANTS

The Board of Trustees has authorized the Area Administrative Offices to refer claims for medical or prescription drug benefits which involve difficult issues as to medical necessity, the nature, classification, scope or duration of care, and the qualification of providers to outside doctors 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 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 consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals procedures.

INTERPRETATION OF THE PLAN

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.

CLAIMS AND APPEALS PROCEDURES

To receive benefits through this Plan, you must identify yourself to the provider of service as a WTWT Retirees 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, copayment or other charge.

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

In most cases, benefits may be assigned for payment directly to the provider. Most billing forms contain a section to assign payment from the Plan directly to your doctor, or hospital. 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 Plan or for charges that exceed those allowable under the Plan.

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.

ADMINISTRATOR	HOW TO SUBMIT CLAIMS	SUBMIT CLAIMS TO
HMO Medical Options		
See HMO's Plan Booklet	See HMO's Plan Booklet	See HMO's Plan Booklet
Trust Medical Plan		
Trust	In most cases, providers submit bills for you. If they don't, 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.	Area Administrative Office
Prescription Drugs		
Medco Health	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
Mental Health and Chemical Dependency — Non-Medicare Retirees Plan		
Health Management Center (HMC)	HMC network providers: No claim form required. Non-HMC providers: Submit a CMS (HCFA)-1500 form (available from HMC).	HMC P.O. Box 14621 Lexington, KY 40512-4621

One-Year Time Limit for Filing Claims

For a claim to officially be considered a claim, you must request the Trust provide benefits for a specific service or supply in accordance with the Plan'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 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 mental health and chemical dependency non-participating providers.

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

Claims Review and Appeal Procedures

If your appeal involves health benefits through an HMO, you must contact that entity. Appeals involving mental health or chemical dependency benefits through Health Management Center must be pursued through HMC. See the information on pages 51-53. 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 Claims

Post-service health claims are properly filed claims for medical or prescription drug 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.

Pre-Service Health Claims

Pre-service health claims are properly filed claims that must be preauthorized to receive full benefits from the Trust. Currently, non-Medicare retirees must preauthorize inpatient hospital admissions, transplants, gastric bypass and obesity surgery.

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, licensed nurse practitioner) with knowledge of the patient's medical condition.

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 Plan 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.

Urgent claims involving mental health or chemical dependency benefits will be processed by HMC under its own procedures. Contact HMC for information regarding making claims of this nature.

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.

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.
- 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.
- An explanation of the Trust's appeal 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. 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 Area 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 the claimant. 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 will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

Appeal Procedures

The following procedures will be the exclusive procedures available to you or your beneficiary who is dissatisfied with an eligibility determination, benefit denial or partial benefit award or any other adverse benefit determination by the Trust or its authorized claims payers. Appeals involving benefits provided through an HMO or mental health or chemical dependency services provided by HMC must use those entities appeal procedures. These procedures must be exhausted before you or your beneficiary may file suit under Section 502(a) of ERISA.

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 Appeal

Claim appeals will be reviewed by the Trust's Appeal Committee, which consists of at least one employer and one labor organization Trustee. A decision will be made within the following time limits:

- Post-Service Claims — An appeal will be presented to the Appeal 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

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 you 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 licensure review a matter if he or she is qualified to treat the condition involved. The Appeals Committee will identify by name any individuals consulted for medical or vocational advice.

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).
- A notice of the claimant's rights under section 502(a) of ERISA.

The Trust provides for no voluntary alternative dispute resolution procedures. If you or your beneficiary remain 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).

Claims Appeal Procedures for HMOs or Insured Providers

If you are appealing benefits denied by an HMO with which the Trust contracts or mental health or chemical dependency benefits through HMC you should follow the procedures outlined by that organization.

Exhaustion of Remedies/Limitations on Actions

No legal or equitable action for benefits under this Plan will be brought unless and until the claimant has, in accordance with the foregoing claims and appeal procedures:

- Submitted a written claim for benefits as required,
- Been notified that the claim is denied (or is deemed 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 Plan may be commenced against the Plan more than 12 months after the issuance of an Appeals Committee's written decision.

Summary Plan Description and Other Information

Name of Plan

Western Teamsters Welfare Trust Health and Welfare Plan for Retirees.

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, WA 98102
(206) 329-4900

Name, Title and Principal Place of Business of Each Trustee

See page 107 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 and mental health and chemical dependency benefits. Different benefits are provided depending on whether or not the individual retiree or dependent is eligible for Medicare.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of contract administrative organizations which provide a Principal Trust Office and Area Administrative Offices, and other providers of services. Contact information for the contract administrative organizations are shown on page 109 of this booklet. For general information about the Plan, contact the Area 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
Principal Trust Office - Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 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 their address listed on page 107.

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 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 (and self-payments by certain employees, retirees and their dependents).

The amount of self-payments required of eligible retirees and spouses are periodically established by the Board of Trustees and set forth in announcement letters and billings issued by the Area Administrative Offices. If you need any information about the contribution rate required of you, contact your Area Administrative Office.

A copy of each of the applicable collective bargaining agreements is available for examination, without charge, by participants and beneficiaries, at the Trust's Area Administrative Offices. 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 at the Principal Trust Office, 2323 Eastlake Avenue East, Seattle, Washington 98102. The Trustees 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 without charge by participants and beneficiaries, upon written request addressed to the Board of Trustees at the Principal Trust Office.

Eligibility for Benefits

The Eligibility rules which describe the requirements under which retirees and their dependents become and remain eligible for benefits under the Plan are set forth on pages 4 to 7 of this booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits

The rules describing the conditions under which the eligibility of retirees and their dependents will terminate are on pages 9-10 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.

Claims Appeal Procedures

The procedures for presenting denied claims for review are on pages 90-94.

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.

Funding Mechanism

The Retirees Plan is funded through negotiated employer contributions and retiree and spouse self-payments. Contributions and self-payments are paid into the Trust Fund and, as authorized by the Board of Trustees, are then allocated to: (a) the payment of premiums or fees to the insurance companies and health care providers who underwrite the benefit coverages and also, for the direct payment of self funded benefits; (b) the payment of administrative expenses; and (c) the maintenance of certain reserves.

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. The Board of Trustees reserves the discretion to modify the Retirees Plan or terminate it completely as the circumstances may require.

TYPE OF BENEFIT	TYPE OF FUNDING
Medical	<p>The Indemnity Medical Benefits are self-funded.</p> <p>Premiums are paid to the health maintenance organizations (HMOs) listed below, to provide medical benefits to participants that elect to participate in these plans:</p> <ul style="list-style-type: none"> • Cimarron Health Plan • Group Health Cooperative • Intermountain Health Care • Kaiser Foundation Health Plan, Inc. - California • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Oregon • PacifiCare of Arizona/Secure Horizons • PacifiCare of California/Secure Horizons • PacifiCare of Colorado/Secure Horizons • PacifiCare of Nevada/Secure Horizons • PacifiCare of Oklahoma/Secure Horizons • PacifiCare of Oregon/Secure Horizons • PacifiCare of Texas/Secure Horizons • PacifiCare of Washington/Secure Horizons • Presbyterian Health Plan
Prescription Drugs	<p>Indemnity Prescription Drug Benefits are administered by Medco Health and are self-funded.</p>
Managed Mental Health and Chemical Dependency Services	<p>Premiums are paid to Health Management Center, Inc. to provide benefits for mental health and chemical dependency services.</p>

Future of the Plan and Trust Fund

The Western Teamsters Welfare Trust is expected to remain in full force and effect until terminated by action of the Trustees. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund. In the event of termination, the Trustees will:

- Make provision out of the Trust Fund 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 Fund in such manner as they determine will carry out the purpose of the Trust, including, but not limited to, the 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.
- 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 Fund 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.

Unless terminated sooner, this Trust will terminate upon the death of the last survivor of the persons entitled to benefits hereunder, provided, however, that if, as and when this Trust without

the benefit of this provision will not violate the rule against perpetuities, then this provision will be of no force or effect, and this Trust will continue in perpetuity unless otherwise terminated.

Maternity Benefits

Under federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours if applicable).

Certificate of Health Coverage

Under the Health Insurance Portability and Accountability Act (HIPAA), if your coverage under this plan stops, you and your covered dependents will receive a certificate that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan, if it excludes coverage for certain medical conditions which exist before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that exist before you enroll. You and your dependents may also request additional certificates within 24 months of losing coverage under this Plan. Such request should be made to your Area Administrative Office.

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 your Area 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.
- 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.

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 Reduce or Eliminate Exclusionary Periods

When your coverage under a group health plan ends, your Area Administrative Office or health insurance carrier should provide you with a certificate of creditable coverage. This certificate will prove to your new employer or new plan that you had coverage. If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods of

coverage for pre-existing conditions when you enroll in a new group health plan. Your group health plan administrator or health insurance carrier should provide a certificate of creditable coverage, free of charge, when:

- You lose coverage under the Plan
- You become entitled to elect COBRA continuation coverage
- Your COBRA continuation coverage ceases
- You request a certificate of creditable coverage before losing coverage, or
- You request a certificate of creditable coverage up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage (18 months if you enrolled late).

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 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.

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 your Area 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 Website at www.irs.gov.

PRIVACY NOTICE

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. This notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information. This notice is also available on the Trust's website at www.westernteamsters.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. 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.

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 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.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor) 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 which 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.

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

- **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.

- **When Legally Required 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 information 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.

- **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.

- **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.

- **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.

- **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.

- **To a Personal Representative**

The Trust may disclose your health information to an individual who is authorized by you or applicable law to serve as your personal representative.

Authorization to Use or Disclose Health Information

Other than as stated on pages 102 through 104, 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 on page 106.

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 on page 106.

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 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.

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 on page 106. 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.

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 on page 106. 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 on page 106. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request may also 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.

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 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 the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

PRIVACY CONTACT PERSON	PRIVACY OFFICIAL
Bob Kromm WTWT Account Executive Northwest Administrators, Inc. 2323 Eastlake Avenue E. Seattle, WA 98102 Phone: (206) 726-3251 Email: bkromm@nwadmin.com	Vice-President of Trust Administration c/o Charlene Lind Northwest Administrators, Inc. 2323 Eastlake Avenue E. Seattle, WA 98102 Phone: (206) 726-3281 Email: clind@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 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.

BOARD OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
<p>John Coulson Roadway Express 1110 S. Reservoir St. Pomona, CA 91766</p>	<p>Randy Cammack Teamsters Local 63 845 Oak Park Road Covina, CA 91724</p>
<p>Don Emery Director of Labor Relations Yellow Freight Systems 10990 Roe Avenue Overland Park, KS 66211</p>	<p>Buck Holliday Teamsters Local 690 1912 N. Division Spokane, WA 99207</p>
<p>A.J. Phillips ABF Freight System 3801 Old Greenwood Road Fort Smith, AR 72903</p>	<p>Jim Santangelo Teamster Joint Council #42 818 Oak Park Road Covina, CA 91724</p>
<p>Jim Roberts Western Motor Carriers, Inc. 566 El Dorado Street, Suite 201 Pasadena, CA 91101</p>	<p>Joe Silva Teamsters Local 70 70 Hegenberger Road Oakland, CA 94621-0170</p>
<p>Bob Davidson Roadway Express 1077 George Blvd. Akron, OH 44310</p>	<p>Ralph Taurone Western Region Freight Office 47 W. 200 S., Suite 300 Salt Lake City, UT 84101</p>

WTWT AREA ADMINISTRATIVE OFFICES

Check with the Principal Trust Office to determine the proper Area Administrative Office for you to file claims or make inquiry regarding the Plan.

Principal Trust Office
 Northwest Administrators
 2323 Eastlake Avenue East
 Seattle, WA 98102
 (206) 726-3235

LOCATION	AREA ADMINISTRATIVE OFFICE
Washington, Oregon, Idaho, Utah, Northern California and Northern Nevada	Northwest Administrators 2323 Eastlake Avenue East Seattle, WA 98102 (206) 726-3235 Toll free: (800) 872-5439
Southern California, Southern Nevada, Arizona and New Mexico	Southwest Administrators P.O. Box 1121 Alhambra, CA 91802-1121 or 1000 South Fremont Avenue, A-9 West Alhambra, CA 91803-4337 (626) 284-4792 Toll free: (877) 350-4792
Montana	William C. Earhart Company, Inc. P.O. Box 4148 3140 Northeast Broadway Portland, OR 97208 (503) 282-5581 Toll free: (800) 547-1314
Colorado and Wyoming	Robert F. May Company 1010 Acoma Street Denver, CO 80204 (303) 629-0931 Toll free: (800) 669-1323
Change of Operations Participants	Southwest Administrators P.O. Box 1130 Alhambra, CA 91802-1130 or 1000 South Fremonth Avenue, A-9 West Alhambra, CA 91803-4337 Toll free: (800) 472-5340

IMPORTANT CONTACT INFORMATION

IF YOU HAVE QUESTIONS OR NEED TO CONTACT	TELEPHONE NUMBER/ONLINE ADDRESS
<i>Area Administrative Offices</i>	
Principal Trust Office	Northwest Administrators at 206-726-3235
Oregon, Idaho, N. California, N. Nevada, Utah and Washington	Northwest Administrators at 206-726-3235 or 800-872-5439
Montana	William C. Earhart Co. at 503-282-5581 or 800-547-1314
Arizona, New Mexico, S. California and S. Nevada	Southwest Administrators at 626-284-4792 or 877-350-4792
Colorado and Wyoming	Robert F. May Co. at 303-629-0931 or 800-669-1323
<i>Care Management Programs</i>	
For Hospital Utilization Review and Pre-certification For Maternity Options Management (MOM) Program For Medical Case Management To locate a preferred provider	Beech Street 877-891-7983 or www.beechstreet.com
For a preferred provider directory	Your Area Administrative Office or online at www.beechstreet.com
<i>Mental Health and Chemical Dependency Benefit Plan — Non-Medicare Only</i>	
Inpatient hospital admissions To arrange for outpatient treatment	Health Management Center (HMC) 800-989-8008 or www.mhn.com
<i>Prescription Drug Benefit Plan</i>	
To locate a Medco retail pharmacy Home Delivery Pharmacy Service	Medco Health 800-711-0927 (800-759-1089 TTY) or www.medcohealth.com
<i>Trust Health Plan Administration</i>	
Medical Plan Benefits or Claims Eligibility ID Cards	Your Area Administrative Office Call the Principal Trust Office to determine the proper Area Administrative Office for you to file claims or make an inquiry about the Plan www.westernteamsters.com
<i>HMO Plans</i>	
Lovelace Health Plan	505-262-7363 or 800-808-7363 www.lovelacehealthplan.com
Group Health Cooperative	206-901-4636 or 888-901-4636 www.ghc.org
Intermountain Health Care	800-538-5038 www.ihc.com
Kaiser Foundation Health Plan of California	800-464-4000 www.kaiserpermanente.org
Kaiser Foundation Health Plan of Colorado	303-338-3800 Denver/Boulder 888-681-7878 Colorado Springs www.kaiserpermanente.org
Kaiser Foundation Health Plan of Oregon (includes Southwest Washington)	503-813-2000 Portland 800-813-2000 www.kaiserpermanente.org
PacifiCare of Arizona—Non-Medicare	800-347-8600

IF YOU HAVE QUESTIONS OR NEED TO CONTACT	TELEPHONE NUMBER/ONLINE ADDRESS
	www.pacificare.com
PacifiCare of California—Non-Medicare	800-624-8822 www.pacificare.com
PacifiCare of Colorado—Non-Medicare	800-877-9777 www.pacificare.com
PacifiCare of Nevada—Non-Medicare	800-347-8600 www.pacificare.com
PacifiCare of Oklahoma—Non-Medicare	800-825-9355 www.pacificare.com
PacifiCare of Oregon —Non-Medicare	800-932-3004 www.pacificare.com
PacifiCare of Texas —Non-Medicare	800-825-9355 www.pacificare.com
PacifiCare of Washington—Non-Medicare	800-932-3004 www.pacificare.com
Presbyterian Health Plan	505-923-5678 or 800-356-2219 www.phs.org
Secure Horizons of Arizona—Medicare	800-347-8600 www.securehorizons.com
Secure Horizons of California—Medicare	800-228-2144 www.securehorizons.com
Secure Horizons of Colorado—Medicare	800-771-4347 www.securehorizons.com
Secure Horizons of Nevada—Medicare	800-347-8600 www.securehorizons.com
Secure Horizons of Oklahoma—Medicare	800-950-9355 www.securehorizons.com
Secure Horizons of Oregon—Medicare	800-533-2743 www.securehorizons.com
Secure Horizons of Texas—Medicare	800-825-9355 www.securehorizons.com
Secure Horizons of Washington—Medicare	800-533-2743 www.securehorizons.com

Western Teamsters Welfare Trust

NOTICE OF PLAN MODIFICATIONS

Appendix to the Health and Welfare Plan for Retirees

Important Notice

The Retirees Plan benefit structure for Medicare Retirees is based on information available to the Trustees at the time the Plan was designed. Should additional changes be made to Medicare benefits beyond those that were known or contemplated by the Trustees or their advisors, at the time these benefits were designed, the Trustees may, at their discretion, make benefit, eligibility or funding changes (including changes to your monthly self-payments or other funding considerations) as they deem necessary.

March 2006

MEMORANDUM

FROM: Western Teamsters Welfare Trust
TO: Plan Participants
RE: Notice of Plan Modifications to Health and Welfare Plan for Retirees

Dear Plan Participant:

Attached is a "Notice of Plan Modifications" to the Health and Welfare Plan for Retirees (September 1, 2004 edition). The page numbers listed refer to your Plan Booklet and this notice should be kept with your Plan Booklet. This notice contains notices required by law, clarifies certain plan provisions and administrative practices, informs you of changes in the Trustees and outlines other modifications. While you should still read this document, the Board of Trustees would emphasize that the overall structure of your benefits has not changed.

Following are some of the more significant changes included within the notice:

- > Changes to reflect certain legal requirements regarding COBRA Continuation Coverage.
- > Language concerning Emergency Room Care Review has been inserted in the Non-Medicare Retiree Indemnity Medical Summary.
- > New language concerning additional benefits available in regards to organ or bone marrow transplants under the Trust Indemnity Plan.
- > New language describing the benefits under the Trust Indemnity Medical Plan for periodontal or dental disease when the need for treatment is due to radiation therapy or chemotherapy.
- > Changes in how mental health and chemical dependency benefits are administered under the Trust Indemnity Medical Plan.
- > New language concerning how coverage is coordinated with other medical plans.

Since this is very important information, please read carefully and keep it with your benefit booklet.

If you have questions about the information presented within the Notice of Plan Modifications, please contact your Area Administrative Office.

WESTERN TEAMSTERS WELFARE TRUST

Notice of Plan Modifications to Health and Welfare Plan for Retirees

This Notice summarizes changes which have been made to the Health and Welfare Plan for Retirees (September 1, 2004 edition). The page numbers listed refer to your Plan Booklet and this Notice of Plan Modifications should be kept with your Plan Booklet.

The changes reflect certain new legal requirements, a change in the Trust's contractual relationship with Health Management Center, the entity which provides chemical dependency and mental health benefits and some changes to some very specific plan provisions. While you should still review these changes, you should be assured that the overall structure of the benefits available to Retiree plan participants in the Western Teamsters Welfare Trust has not been changed.

- 1. Replace the Plan language under the heading COBRA Continuation Coverage, (page 17 - 20) with the following:**

COBRA CONTINUATION COVERAGE - RETIREES

COBRA is a federal law which 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 qualified beneficiaries and also requires that they notify the Trust in certain situations.

Self-payments for Coverage (COBRA)

Under the circumstances described below, each qualified beneficiary has an independent right to elect to continue Trust health coverage beyond the time coverage would ordinarily have ended pursuant to a federal law known as COBRA.

Notices to Trust Concerning COBRA

The Area Administrative Office serving your area is responsible for administering COBRA continuation rights for you. All communications must be made in writing; identify you; the retiree, if different; the Trust's name and be sent to your Area Administrative Office. The Area Administrative Offices and their addresses are listed in your Plan Booklet.

Qualifying Events

The dependent of a participating retiree has the right to elect continuation of your health coverage from the Trust in the following situations:

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

- Death of the Participating Retiree;
- Divorce or legal separation from the Participating Retiree; or
- The Participating Retiree becoming entitled to Medicare.

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

- Death of the Participating Retiree;
- Divorce or legal separation from the Participating Retiree;
- The Participating Retiree becoming entitled to Medicare; or
- The child no longer qualifies 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 have the responsibility to inform the Trust Office of a loss of coverage resulting from a divorce, legal separation or a child losing dependent status. **You must notify the Trust Office in writing at the address listed above 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 retiree'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.

Election of COBRA

Once the Trust Office has received proper notice that a qualifying event has occurred, it will notify the eligible dependents of their right 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 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 notice must be sent to your Area Administrative Office. Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

Available Coverage

You may continue the coverage(s) and the plan option you had as of your qualifying event. If you elect COBRA, you may change the coverage to or from an HMO option available through the Trust for which you are eligible during the Trust's annual open enrollment period or an event creating special enrollment rights occurs.

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. If you elect COBRA and acquire a new dependent through marriage, birth, adoption or placement for adoption, though, you may add the new dependent to your COBRA coverage by providing written notice to the Trust Office within 60 days of acquiring the new dependent. The written notice must identify the individual on COBRA, the new dependent, the Trust, the date the new dependent was acquired and be mailed to your Area Administrative Office.

Continuous Coverage Required

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

Cost

A qualified beneficiary must pay the entire cost of the continuation coverage, which includes a 2% administration fee. The cost for the coverage available through the Trust is set annually.

Monthly Self-Payments Required

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 Office at the address listed above. 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 coverage may be made up to 45 days after the date of election. Your initial payment must cover all 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 coverage, your right to continuation coverage will be lost.

Length of Continuation Coverage

Continuation of coverage may last for up to 36 months. 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 36-month continuation period:

A required self-payment is not paid to the Trust Office on a timely basis for the next monthly coverage period;

A qualified beneficiary becomes covered under any other group health plan after the date of his or her COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage);

A qualified beneficiary provides written notice that he or she wishes to terminate your coverage;

A qualified beneficiary become entitled to Medicare benefits after the date of his or her COBRA election; or

The date the Plan terminates.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA 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, 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 first and the Trust will only pay secondary and coordinate with Medicare. 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.

Alternative Coverage Through Western Teamsters Welfare Trust

The Trust's medical (including chemical dependency and mental health) and prescription drug programs offer no conversion option.

If you participate in an HMO option available through the Trust, you may have alternative coverage options including a conversion option and self-payment rights under state continuation laws which may differ from COBRA. If you participate in an HMO option and wish more detail, please contact the HMO. The contact addresses for the HMOs available through the Trust are listed in your Plan Booklet or are available from your Area Administrative Office.

Generally, you must apply for conversion coverage within strict time limits (often 31 days or less). You should be aware that if you enroll in an individual conversion plan, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law: 1) You can lose the right to avoid having pre-existing condition exclusions apply to you under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap; 2) You can lose the right to purchase guaranteed individual health coverage that does not impose a pre-existing condition exclusion if you do not obtain a continuation coverage for the maximum time available to you; and 3) You should be aware that federal law gives you special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

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/esba.

Keep Your Plan Informed of Address Changes

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

The previously adopted language concerning Emergency Room Care Review should be inserted in the Non-Medicare Retiree Indemnity Medical Summary, p. 24.

BENEFITS/SERVICE	IF YOU USE PPO PROVIDERS, PLAN PAYS	IF YOU USE NON-PPO PROVIDERS, PLAN PAYS
Emergency Room Care	<p>You pay \$100 co-pay per visit, then the Plan pays 80% PPO allowed amount after deductible if due to illness.</p> <p>Deductible waived for treatment of injury within 48 hours of covered accident or if admitted.</p>	<p>You pay \$100 co-pay per visit, then the plan pays 60% of UCR after deductible.</p> <p>Deductible waived for treatment of injury within 48 hours of covered accident or if admitted.</p>

Amend Covered Expenses In or Out of the Hospital - Organ and Bone Marrow Transplants (page 28) to add the following language:

Donor Costs

Covered services include: selection, removal (harvesting) and evaluation of the donor organ, bone marrow, or stem cell; 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 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).

- 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.

This change is effective November 17, 2005.

4. Amend the Indemnity Medical Benefits Exclusions (page 34 and 64) to add the following italicized language to Exclusion 10.

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

* * *

10. "Peridontal or dental disease or any condition involving the teeth, surrounding tissue or structure, or alveolar process of 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.*"

This change is effective November 17, 2005.

5. Changes to Administration of Mental Health and Chemical Dependency Benefits

Effective September 1, 2005, the Trust's mental health and chemical dependency benefits became self-funded. The benefits provided you remain the same but various administrative details are different given the change in how the benefits are provided: All references to Health Management Center, Inc. or HMC should now refer to MHN Services or MHN; certain provisions related to the insured nature of the relationship with MHN have been deleted; and, the provisions related to handling of appeals involving mental health and chemical dependency benefits set out on pages 52 - 54 of the Plan Booklet have been replaced in their entirety to reflect that these benefits are now self-funded.

a. The following paragraphs are deleted in their entirety:

HMC is licensed in the State of California as a specialized health care service plan and regulated by the Department of Corporations. For eligible participants outside the State of California, benefits are administered by HMC. For more information about behavioral health care services, call 800-260-6076 and request an Evidence of Coverage (EOC). The EOC provides a detailed explanation in Schedule A of the Appendix.

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* * *

If an HMC network provider is terminated, breaks their contract, or is unable to perform their duties, HMC will notify you and the Trust within a reasonable time. Upon termination of an HMC network provider, HMC remains liable for medically necessary and clinically appropriate covered services undertaken by the provider (other than co-payments) until the services have been completed. HMC may make reasonable and medically appropriate provisions for the assumption of these services by another HMC network provider.

Every contract between HMC and HMC network providers and facilities states that in the event that HMC fails to pay the involved network provider or network facility, you and your dependents are not responsible for any sums owed by HMC to the provider or facility.

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b. New Appeal Language

Requests for Appeals of Denials of Authorizations Can Be Made By Members, Providers, or Facilities

Questions about the stages of the appeal processes handled by MHN may be directed at any time to the MHN Appeals Unit at (888) 426-0028. Questions concerning the final stage of the appeal process for pre-service and post-service claims should be directed to the participant's Area Administrative Office.

The following appeal procedures will be followed for appeals involving mental health and chemical dependency services. Appeals involving other types of benefits are set out on pages 94 - 96 of the Plan Booklet.

Types of Appeal

There are four potential types of claims involving mental health and chemical dependency benefits which are subject to these appeal procedures:

Urgent Care Claims

Urgent care claims are any claim for medical care or treatment that has not been provided by the date of your claim, where applying standard processes for making care decisions:

Could seriously jeopardize your life, health or ability to regain maximum function; or

Would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Determinations regarding the severity of pain must be made by a physician with knowledge of your medical condition.

If a physician with knowledge of your medical condition determines that your claim is an urgent care claim, MHN will treat it as such. A health care professional with knowledge of your medical condition may act as your authorized representative for filing and appealing an urgent care claim.

Concurrent Care Claims

A concurrent care claim involves a request for authorization of an extension or modification to an approved course of treatment that is already in progress, such as an inpatient hospitalization.

Pre-Service Claims

A pre-service claim is a request for authorization of medical care or treatment that has not been provided by the date of your claim, that depends in whole or in part on MHN's approval of coverage in advance of obtaining the medical care. The following services must be preauthorized:

Mental health inpatient, residential, partial hospitalization and intensive outpatient levels of care; and

Chemical dependency detoxification, inpatient rehabilitation, residential, partial hospitalization and intensive outpatient levels of care.

Post-Service Claims

A post-service claim is a request for payment or reimbursement of costs for medical care that has already been provided and which is not an urgent care claim or a pre-service claim.

Handling of Urgent Care and Concurrent Care Appeals

Urgent and concurrent appeals require an accelerated response and MHN will make a final determination on urgent and concurrent appeals in the circumstances described below and provide the necessary notice to the participant involved.

Urgent Care Claims

MHN will notify the participant of its decision (whether or not to pay the claim) as soon as possible, taking into account medical exigencies, but not later than 72 hours after MHN's receipt of an urgent care claim.

If a participant fails to provide MHN with information sufficient for MHN to decide on an urgent care claim, the participant will be notified as soon as possible, but not later than 24 hours after MHN's receipt of the insufficient information. The participant will have a reasonable amount of time, but not less than 48 hours, to provide the specified information. After the participant provides the specified information, MHN will provide its decision on the claim as soon as possible, but in no later than 48 hours after the earlier of:

MHN's receipt of the specified information; or

The end of the period afforded the participant to provide the specified additional information.

Concurrent Care Claims

If MHN has approved an ongoing course of treatment to be provided to a participant for a period of time or number of treatments, MHN's reduction or termination of the course of treatment (other than by amendment or termination of this Plan) will constitute a claim denial. Any reduction or termination by MHN of the approved course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed, is considered an adverse benefit determination. In the event of such a denial, MHN will notify the participant in sufficient time prior to the reduction or termination in order to allow an appeal and an

opportunity to obtain a determination on appeal before the ongoing course of treatment is reduced or terminated.

If the participant requests that the course of treatment be extended beyond the period of time or number of treatments originally approved and such request is an urgent care claim, the request will be handled as such according to the procedures for urgent care claims.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the request to extend treatment is a non-urgent circumstance, the request will be considered a new claim and decided according to pre-service claim or post-service claim procedures set forth below.

Handling of Pre-Service and Post-Service Claims

On pre-service and post-service claim appeals MHN shall handle the first level of appeal pursuant to the following procedures with any final review being done pursuant to the Trust's claims appeal procedures.

Pre-Service Claims

MHN will notify the participant of its decision (whether or not to pay the claim) as soon as possible but no later than 15 days after MHN's receipt of a pre-service claim.

MHN reserves the right to a single extension of this 15-day period for an additional 15 days if MHN determines that the extension is necessary due to matters beyond its control. The participant will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of the time and date by which MHN expects to provide a decision.

If the extension described above is necessary because the participant has failed to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. The participant will have at least 45 days from the receipt of such notice to provide the specified information.

If the participant remains dissatisfied with MHN's determination on any pre-service claim, any further appeal shall be made pursuant to the appeal procedures of the Western Teamsters Welfare Trust.

Post-Service Claims

On any post-service claim, MHN will notify the participant of its decision as soon as possible but not later than 30 days after MHN's receipt of the post-service claim. MHN reserves the right to a single extension of this 30-day period, for up to an additional 15 days, if MHN determines that the extension is necessary due to matters beyond its control. The participant will be notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension of the time, and the date by which MHN expects to provide a decision.

If the extension is because the participant failed to submit the information necessary to decide the claim, the notice of extension will describe specifically the required information. The participant will have at least 45 days from the receipt of such notice to provide the specified information.

If the participant remains dissatisfied with MHN's determination on any post-service claim, any further appeal shall be made pursuant to the appeal procedures of the Western Teamsters Welfare Trust.

Contact Information

You may contact MHN for any appeal stays which it is handling by contacting:

MHN Appeals Unit
1600 Gamos Drive, Suite 300
San Rafael, CA 92647
(888) 426-0082

For any stage of the appeal involving the Trust, you may submit your appeal to your Area Administrative Office. The addresses for the Area Administrative Offices are listed on page 120 of your Plan Booklet.

This change is effective September 1, 2005.

6. Amend the Coordination of Coverage With Other Plans - Effect on Benefits (page 87) by adding the following paragraph:

"If another plan which is primary under this Plan's coordination of benefit rules limits the available benefits based on the existence of other group health coverage, this Plan 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 Plan."

This change is effective November 17, 2005.

Update the membership of the Board of Trustees (page 109) to remove Benjamin Throop and add the following under Employer Trustees:

Bob Davidson
Roadway Express
1077 George Blvd.
Akron, OH 44310

Update the Summary Plan Description - Funding Mechanism (page 100) to provide as follows:

<u>Type of Benefit</u>	<u>Type of Funding</u>
Managed Mental Health and Chemical Dependency Services	Indemnity mental health and chemical Dependency services for non-Medicare Retirees are self-funded and administered by MHN Services.

This change is effective September 1, 2005.

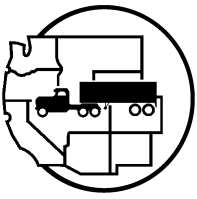
9. Acquisition of Cimarron Health Plan By Lovelace Health Plan

On pages 1, 23, 100 and 111 of the Plan Booklet, references are made to Cimarron Health Plan in New Mexico. Cimarron Health Plan has been acquired by Lovelace Health Plan. The contact information is:

Lovelace Health Plan
1-800-808-7363
www.lovelacehealthplan.com

NOTICE OF AVAILABILITY OF PRIVACY NOTICE

The Western Teamsters Welfare Trust maintains a Notice of Privacy Practices. This Notice explains the possible uses and disclosures of protected health information by the Trust. It also outlines your rights in regards to your health information and the steps the Trust has taken to prevent unnecessary disclosures. A copy of the Notice of Private Policy can be found in your Plan Booklet beginning at page 114 or requested separately from your Area Administrative Office. It can also be found at the Trust's website at www.westernteamsters.com.



Western Teamsters Welfare Trust

An Employer-Employee Jointly Administered Welfare Trust

2323 Eastlake Avenue East • Seattle, Wa. 98102-3393 • Phone (206) 329-4900

TO: Indemnity Plan Actives, Casuals and Non-Medicare Retirees Covered Under the Medco Prescription Drug Plan

FROM: Board of Trustees

RE: Change in Prescription Drug Co-Payments -**Effective July 1, 2007**

The Trust has changed the co-payments under the prescription drug plan administered by Medco for actives, casuals and non-Medicare retirees. The changes are effective with prescriptions filled on or after July 1, 2007. The purpose of the change is to encourage participants' use of generic drugs and mail order for maintenance medications. The current co-payments and the new co-payments are described below.

Current Co-Payments

Retail Pharmacy (30 Day Supply)

Generic Drugs - \$10

Brand Drugs - 20% w/\$15 min.

Mail Order (90 Day Supply)

Generic Drugs - \$10

Brand Drugs - \$30

New Co-Payments (July 1, 2007)

New Retail Pharmacy (30 Day Supply)

Generic Drugs - 20% w/\$10 minimum

Brand Drugs - 20% w/\$25 minimum

New Mail Order (90 Day Supply)

Generic Drugs - No-Copay

Brand Drugs - \$50

The reasons for the change are that brand drugs and prescription filled at retail cost significantly more. The average cost of a WTWT retail generic prescription is \$50.21 and the average cost of a mail order generic prescription is \$175.08. Compare these generic drug costs to those of the average brand name drug \$116.23 for a retail prescription and \$398.10 for a mail order prescription. As you can see, the cost of generic drugs is substantially less than that of brand name drugs. Additionally, the Trust receives greater discounts on drugs filled through mail order. The Trustees encourage you to use generic drugs and mail order whenever possible in order to save money for you and the Trust.

If you have any questions about the new prescription drug co-payments please call your Area Administrative Office.