Your Joint Benefit Trust Health Benefits

Effective January 1, 2012, a number of changes in the Joint Benefit Trust (JBT) 1400 HOUR PLAN will take effect. Some are benefit improvements required by changes in the law, while other changes affect longstanding features of the 1400 HOUR PLAN by increasing how much you pay for coverage. This brochure explains these changes so please read it carefully.

Contact the Trust Fund Office at 1-800-JBT-HELP (1-800-528-4357) if you have questions. You can also visit the JBT website at www.jointbenefittrust.com to find information about the Trust Fund, your other health and welfare benefits, and provider contact information.

You Will Pay $30 of the Monthly Employer 1400 Hour Plan Contribution

Your employer's contributions to JBT pay the costs for your health, prescription drug, and other welfare benefits.

In the final year of the current Teamsters/CPI contract, the employer contribution for the 1400 Hour Plan is capped at $1,190 per employee per month. However, the cost of the benefits provided through the 1400 Hour Plan has increased to $1,220 per employee per month. To make up this shortfall, $30 per month will be deducted from1400 Hour Plan employee paychecks starting in January 2012.

To keep the cost of the Plan—and your monthly payment—as low as $30 per month, the Trustees had to make changes to the 1400 Hour Plan as described in this brochure. Without these changes, **the Plan would have cost $1,290 per month, and your share would have been $100 per month.**

Your employer will continue to pay $1,190 per month for your health and welfare benefits. Your co-contribution of $30 per month is just 2½% of the total premium cost of $1,220 per employee per month.

Reminder: Open Enrollment is Coming Soon!

Each December, JBT sponsors an open enrollment for medical coverage. You can elect a medical plan during this time. You can also add or drop coverage for your dependents during open enrollment.

You will receive information about open enrollment in early December. Your packet will include detailed benefit summaries and an enrollment form. The elections you make during open enrollment will go into effect on January 1, 2012.

Watch for your enrollment packet in your home mail.

Coverage Improvements for Preventive Care—Effective January 1, 2012

Effective January 1, 2012, the 1400 Hour Plan will cover certain preventive services at 100%. To receive 100% coverage you must use a **network provider.** However, you will not need to meet a deductible or make any copayment for these services.

	Coverage before January 1, 2012	Coverage Effective January 1, 2012
Coverage of Preventive Care Services	No coverage for: ○ Routine physical exams ○ X-rays and lab work related to routine physicals ○ Preventive care generally ○ Well baby care ○ Routine pediatric tests ○ Immunizations for children or adults	The preventive care services listed on pages 7 – 8 of this notice, including routine physicals and the related lab tests and x-rays, are covered at 100% if you use an Anthem Blue Cross PPO provider. To receive 100% coverage for an annual mammogram, you must use a provider in the Mammography Center Network. The Plan deductible and out-of-pocket maximum do not apply to these preventive care services.

JBT Medical Plan Coverage Changes—Effective January 1, 2012

Higher Annual Deductible—The annual deductible is the amount you owe for covered health care services before the Plan begins to pay claims. The deductible accumulates separately for care received in-network (Anthem Blue Cross) versus care received out-of-network (not Anthem Blue Cross).

For information about network providers, go to the Anthem Blue Cross website at **www.anthem.com/ca**

Annual Deductible	Current Benefit		Changes Effective January 1, 2012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Family	$200 $500	$400 $1,000	$300 $750	$600 $1,500

Higher Co-insurance—Co-insurance is a percentage of the allowed charge for a service, shared by you and the Plan. Co-insurance applies after you meet your annual deductible.

Co-insurance	Current Benefit		Changes Effective January 1, 2012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital Care	Plan pays 100% of allowed charge	You pay 30% of allowed charge	You pay 10% of allowed charge	You pay 50% of allowed charge
Outpatient Care	You pay 20% of allowed charge	You pay 30% of allowed charge	You pay 20% of allowed charge	You pay 50% of allowed charge

Higher Out-of-Pocket Maximum—This maximum limits how much you pay in a given year if you have a serious illness or injury.

Out-of-Pocket Maximum	Current Benefit		Changes Effective January 1, 2012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	$2,000	$4,000	$3,000	$6,000

Changes in Prescription Drug Coverage (if you are NOT in an HMO)—Effective January 1, 2012

Starting in January, some drugs won't be covered. The JBT will introduce a new list of covered drugs (called the "formulary list"). **If a drug is not on the formulary list, it will not be covered.**

The new "formulary list" will include the most cost-effective drugs for treating various classes of conditions and illnesses—for example, drugs to lower cholesterol, drugs to treat allergies, and drugs for diabetes. The new formulary list will include mostly generic medications and some brand name medications. The new formulary list will be available through the JBT website at **www.jointbenefittrust.com**, before January 1, 2012. You can also request a copy from the Trust Fund Office.

Contact CVS Caremark

Member Services
1-888-685-7752

Mail Order
1-800-552-8159

Exceptions/pre-authorization
1-800-294-5979
www.caremark.com

What's a "Brand Name" Drug and What's a "Generic"? A "brand name" drug is a medication sold under a trademark-protected name, such as the drug "Tenormin," which is a beta blocker used to treat high blood pressure. Brand name medications can be made and sold only by the company that holds the patent for the drug. When the patent of a brand name medication expires, a "generic" version of the drug can be produced and sold by other drug makers. Generic versions of a drug must use the same active ingredients as the brand name drug, and it must meet the same quality and safety standards.

Your current copayments for formulary generic and brand drugs will not change. However, if you choose a non-formulary drug, you will pay its full cost.

Generic Drug on the JBT Formulary List	Brand Drug on the JBT Formulary List	Drugs Not on the JBT Formulary List
$10 copay (30-day supply at retail pharmacy) $20 copay (90-day supply through mail order)	$20 copay (30-day supply at retail pharmacy) $40 copay (90-day supply through mail order)	Not covered; you pay full cost

If you or a dependent are enrolled in JBT's Health Matters Chronic Disease Management program, the following change in drug coverage applies for drugs related to your condition:

Generic Drug on the JBT Formulary List	Brand Drug on the JBT Formulary List	Drugs Not on the JBT Formulary List
$0 copay (30-day supply at retail pharmacy) $0 copay (90-day supply through mail order)	$20 copay (30-day supply at retail pharmacy) $40 copay (90-day supply through mail order)	Not covered; you pay full cost

You will receive a letter from CVS Caremark if any of your current prescriptions are drugs not on the formulary list. Or, you and your doctor will be able to determine if all of your prescriptions are on the formulary list by calling CVS Caremark at 1-800-294-5979. Provide your CVS Caremark member ID number when you call. If one or more of your current medications is not on the list, your doctor can work with CVS Caremark to find a suitable replacement that is on the formulary list.

Note: Only you and your doctor can decide whether switching to a replacement drug is appropriate for you. If you have tried other alternatives that did not work, for example they provided an inadequate effect or significant side effects, your doctor may request an exception with CVS Caremark. If approved, the regular copay for formulary generic or formulary brand drugs will apply.

Coverage for Routine Total Hip and Total Knee Replacement Surgery—Effective January 1, 2012

Starting in January, certain Blue Cross Network **"Designated Hospitals"** will limit their facility charges to $30,000 for total hip or total knee replacement. As of that date, JBT will not pay facility charges higher than $30,000 for these procedures.

Here is how the program works.

If You Visit an Anthem Blue Cross Designated Hospital	If You Visit another Anthem Blue Cross Network Hospital	If You Visit an Out-of-Network Hospital
1. After paying your annual deductible, you pay 10% co-insurance until you meet the out-of-pocket maximum. 2. The Plan pays the balance.	1. After paying your annual deductible, you pay 10% co-insurance until you meet the out-of-pocket maximum. 2. The Plan pays the remaining balance, up to $30,000. 3. You pay any **additional amount** above $30,000.	1. After paying your annual deductible, you pay 50% co-insurance until you meet the out-of-pocket maximum. 2. The Plan pays the remaining balance, up to $30,000. 3. You pay any **additional amount** above $30,000.

The following hospitals in Northern California are on the Anthem Blue Cross Designated Hospital list for total hip and knee replacement. You also can get a copy of the Designated Hospital list through the Trust Fund website at **www.jointbenefittrust.com**, or request a copy from the Trust Fund Office.

Designated Hospital	City	Designated Hospital	City
Dameron Hospital	Stockton	Methodist Hospital of Sacramento	Sacramento
El Camino Hospital	San Jose	Queen of the Valley Medical Center	Napa
Enole Medical Center	Chico	Santa Rosa Memorial Hospital	Santa Rosa
French Hospital Medical Center	San Francisco	Sonora Regional Medical Center	Sonora
Fresno Surgical Hospital	Fresno	St. Agnes Medical Center	Fresno
Good Samaritan Hospital	San Jose	St. Mary's Medical Center	San Francisco
Hanford Community Medical Center	Hanford	Stanislaus Surgical Hospital	Modesto
Healdsburg District Hospital	Healdsburg	UC Davis Medical Center	Sacramento
Kaweah Delta Medical Center	Visalia	UCSF Medical Center	San Francisco
Mercy Medical Center	Redding	Valleycare Medical Center	Pleasanton

If you are planning routine total hip or total knee replacement surgery, be sure to call the Trust Fund Office at 1-800-JBT-HELP (1-800-528-4357) to confirm you are working with a Designated Hospital for your surgery. You also need to pre-authorize any inpatient hospital visit with Anthem Blue Cross by calling 1-800-274-7767.

Benefit Changes for Kaiser Members—Effective January 1, 2012

Starting in January, the cost sharing between you and Kaiser for most services will change. The table below provides a summary. (Note: The current Kaiser annual deductible of $500 for individuals and $1,000 for families is NOT changing.)

Plan Feature	Current Benefit	Changes Effective January 1, 2012
Copayments	$10 copay	You pay 20% co-insurance for most services, instead of the current flat-dollar copay; the annual deductible may also apply
Co-insurance	You pay 10% of allowed charges	You pay 20% of allowed charges
Out-of-Pocket Maximum	$3,000 individual $6,000 family	$4,000 individual $8,000 family

Benefit Changes for UnitedHealthcare (formerly PacifiCare) Members—Effective January 1, 2012

Starting in January, you will need to meet an annual deductible before the Plan begins to pay claims: **$500 for individuals** and **$1,000 for families**. The deductible applies to all services (with the exception of preventive care).

New Appeals Procedures if Your JBT Medical Plan Claim is Denied—Effective January 1, 2012

Starting in January, if you are enrolled in the JBT Medical Plan and your claim is denied, you appeal and your appeal is denied by the Board of Trustees, you may be entitled to seek an external review by an Independent Review Organization ("IRO"). (Note: If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending.)

If the Trustees deny your appeal, you may request an external review of your claim if your claim involves a medical judgment. For example, decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit are eligible for external review. External review is also available if your coverage has been rescinded or terminated on a retroactive basis.

You must submit your written request within four months of the date you were notified of the denied appeal. JBT will review your request within five days to determine whether it is eligible for external review.

Your claim may not be eligible for review if:

- You have not exhausted your internal appeal.
- Your claim involves a determination that you did not meet the Plan's eligibility requirements.
- Your claim sought a benefit that was not covered by the Plan. JBT will inform you of any issues with your request within one day of completing its review. If your request is eligible for review, but incomplete, JBT will contact you regarding the information needed to complete the request. You must provide the required information within the four-month filing period.

If your claim is eligible for external review, it will be submitted to an accredited IRO together with any documents and information used by JBT when considering your claim and internal appeal. The IRO will inform you when it has received your claim. You will have ten days to submit any additional information in support of your appeal. If you submit new information, the IRO will share it with JBT, which may reconsider your internal appeal.

The IRO will make independent medical and legal decisions concerning your claim. The IRO will issue its decision within 45 days of receiving your claim for review. If the IRO decides that JBT must provide additional benefits, the Trust will carry out the decision. However, the Trust may challenge the IRO's decision by bringing suit against any necessary parties. If the IRO determines that the internal appeal decision was correct, and you disagree with that decision, you may bring legal action against the Plan. However, your action must be brought within one year of the IRO's decision.

JBT will review your request immediately to determine whether it is eligible for external review if your appeal involves:

- A medical condition where the standard external review timeframe would seriously jeopardize your life or health, or ability to regain maximum function and you previously requested an expedited appeal to the Trustees
- An admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility

Under these circumstances, your claim will be referred as soon as possible to an IRO. You will be informed of the IRO's decision within 72 hours of receipt of the claim for review. If the initial notice is not provided in writing, you will receive written confirmation of the decision within 48 hours of the initial notice.

You are not required to seek external review by an IRO. You may, instead, challenge the Trustees' denial of an internal review by bringing legal action against the Trust within one year of the date of your appeal's denial.

Preventive Services Covered under the JBT 1400 Hour Plan— Effective January 1, 2012

This list is current as of October 30, 2011. For changes in the list of Preventive Services Covered under the Affordable Care Act, visit **www.healthcare.gov**.

Covered Preventive Services for Adults (Men and Women)	Additional Covered Preventive Services for Women, Including Pregnant Women
○ Abdominal Aortic Aneurysm: One-time screening for men of specified ages who have ever smoked ○ Alcohol Misuse screening and counseling ○ Aspirin use for men and women of certain ages ○ Blood Pressure screening for all adults ○ Cholesterol screening for adults of certain ages or at higher risk ○ Colorectal Cancer screening for adults over 50 ○ Depression screening for adults ○ Type 2 Diabetes screening for adults with high blood pressure ○ Diet counseling for adults at higher risk for chronic disease ○ HIV screening for all adults at higher risk ○ Immunization vaccines for adults: Doses, recommended ages, and recommended populations vary: » Hepatitis A » Hepatitis B » Herpes Zoster » Human Papillomavirus » Influenza » Measles, Mumps, Rubella » Meningococcal » Pneumococcal » Tetanus, Diphtheria, Pertussis » Varicella ○ Obesity screening and counseling for all adults ○ Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk ○ Tobacco Use screening for all adults and cessation interventions for tobacco users ○ Syphilis screening for all adults at higher risk	○ Anemia screening on a routine basis for pregnant women ○ Bacteriuria urinary tract or other infection screening for pregnant women ○ BRCA counseling about genetic testing for women at higher risk ○ Breast Cancer Mammography screenings every 1 to 2 years for women over 40 ○ Breast Cancer Chemoprevention counseling for women at higher risk ○ Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women ○ Cervical Cancer screening for sexually active women ○ Chlamydia Infection screening for younger women and other women at higher risk ○ Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs ○ Domestic and interpersonal violence screening and counseling for all women ○ Folic Acid supplements for women who may become pregnant ○ Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes ○ Gonorrhea screening for all women at higher risk ○ Hepatitis B screening for pregnant women at their first prenatal visit ○ Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women ○ Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older* ○ Osteoporosis screening for women over age 60 depending on risk factors ○ Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk ○ Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users ○ Sexually Transmitted Infections (STI) counseling for sexually active women ○ Syphilis screening for all pregnant women or other women at increased risk ○ Well-woman visits to obtain recommended preventive services for women under 65

Preventive Services Covered under the JBT 1400 Hour Plan—Effective January 1, 2012 *(continued)*

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Blood Pressure screening for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

This Notice is intended to amend all Joint Benefit Trust documents, notices and correspondence, including (but not limited to) 1400 Hour Plan *Summary Plan Description*. This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the Summary Plan Description. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.