Important Information
Summary of Recent Changes to Your Benefits Under the
Teamsters Plan E Post-Employment Benefit (PEB)

May 2017

With this notice, the Board of Trustees announces the following changes to the Post-Employment Benefit (PEB) in the Teamsters Plan E Plan of Benefits.

Please read this notice carefully. This notice makes certain changes to your benefits and amends the provisions of your Summary Plan Description (SPD). Please keep a copy with your SPD and share it with your family.

The required annual notice concerning reconstructive surgery after a mastectomy and reminder to complete your **2017 Annual Information Request Form (AIR) are also included in this mailing (see below).**

October 2016 Restatement of the Teamsters Plus Plan SPD Clarifications in the Schedule of Benefits

Bariatric Surgery – the plan will cover only one bariatric surgery per Participant per lifetime.

Dental Benefit – the limit of two (2) exams per calendar year, refers only to "non-problem focused exams". If you have an exam related to a potential problem identified by your dentist, whether such exam is performed by your regular dentist, another dentist or a specialist, such exam is covered in addition to the two (2) annual regular "non-problem focused exams" already covered by the Plan.

Dental Benefit – coverage of four (4) bitewing x-rays per calendar year is a reiteration of a limitation that has always been in the Plan; however, language regarding this coverage was omitted from the previous SPD (2007 edition). The 2002 SPD contained language limiting the coverage to one (1) full set of x-rays per calendar year (four bitewing are included in a full set of x-rays).

The following change is effective January 1, 2017:

Teamsters RX is now Allegiant RX!

For Participant services please call 1-866-888-0103! This phone number has been changed on the back of your new ID card! Also, please use www.AllegiantRx.com to manage your prescriptions.

The following changes are effective May 1, 2017:

Vision Benefit

Routine Eye Examinations for all adult participants will be covered once every 12 months, along with eyeglass lenses, including contact lenses. Previously, the Plan covered a routine eye exam once every 24 months. All other aspects of the Vision Benefit will remain the same <u>including frames</u>, which are covered once every 24 months.

DOT Physicals

DOT physicals will now be covered once every 12 months, if required, for Covered Employees Only, in addition to the Routine Physical Exam. Previously, the Plan covered DOT Physicals once every 24 months.

Weekly Accident & Sickness Benefits

The Plan of Benefits was amended to allow a Licensed Drug and Alcohol Counselor to sign the Disability form disabling an Employee in Covered Employment as long as the Employee is using a substance abuse professional (SAP) through HMC HealthWorks. Previously, only a doctor of medicine (M.D.) or podiatrist (D.P.M.) were allowed to authorize a Disability.

Breast Pumps

The Plan of Benefits was amended to provide coverage for breast pumps as follows:

- Rental of a hospital-grade electric pump while the baby is in the hospital or for 12 months after delivery is covered at 100%.
    - The purchase of a heavy duty electrical (hospital grade) breast pump is not covered.
- Once discharged, a standard electric breast pump purchase, covered at 100%, within the first 60 days from delivery. Participant is allowed to purchase a standard electric breast pump once every 36 months.
- Manual breast pump purchase, covered at 100%, within the first 12 months from delivery.
- Breast pump supplies, covered at 100%.
- Repair and maintenance of a broken breast pump if the Participant's pump was broken, the Participant had another baby, and it was prior to the 36-month period for when a new pump can be purchased.
- The Plan will not cover the purchase and rental of a breast pump at the same time.

COBRA Continuation Coverage

The COBRA Provisions of the SPD (October 2016 restatement) have been clarified to explicitly allow for a special enrollment option for Dependent Children losing coverage through no fault of their own if:

- A Dependent Child is not included in a COBRA election and has had substantially similar coverage from the election until the loss of coverage.

THE FOLLOWING REMINDERS ARE FOR YOUR INFORMATION ONLY
These are <u>NOT</u> changes to your Plan.

- **<u>Grandfathered Status</u>**

The Board of Trustees believes that the Teamsters Plus Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

- **Home Health Equipment Benefit**

The Plan provides certain **Durable Medical Equipment,** at no cost to you, with a prescription from your physician. Even if the equipment you've been prescribed is not available at no cost, it may be covered under the Major Medical Expense Benefit. Prior authorization is required for coverage of Durable Medical Equipment under the Major Medical Expense Benefit. Please contact either the **Home Health Equipment Department** at **1-203-876-3100 x272** or the **Teamsters Medical Review Program** at **1-800-888-9255** for more information.

- **Coordination of Benefits with Medicare during the Pending Termination Period**

If a Participant (Employee or Dependent) is covered by Medicare and is *also* covered by the Plan because the Employee is actively employed, the Plan pays first (the Plan is the primary payor), before Medicare (the secondary payor), under federal law (the Medicare Secondary Payor Statute). However, Medicare pays first (primary payor) when coverage in the Plan is not based on active employment, such as COBRA coverage. The Pending Termination Period is the first six months of COBRA coverage. Therefore, during the Pending Termination Period, Medicare is the primary payor (coverage during the Pending Termination Period is *not* based on active employment).

In order for Medicare to pay your benefits as primary you must be enrolled in Medicare Parts A and B. Medicare Part A (coverage for hospitalization) is provided automatically and at no cost. Medicare Part B (coverage for medical professionals) requires that you enroll during an enrollment period and pay the required premiums. AND in order for the Plan to provide secondary coverage, you must have Medicare coverage - you **MUST** enroll in Medicare Part B.

EXCEPTION

The Plan provides for an exception to this rule regarding Coordination of Benefits with Medicare during the Pending Termination Period:

If you are:

- Medicare-eligible (either the Participant or Dependent) and
- you are in the Pending Termination Period and
- the Employee is not retired, but is in "lay off" status (a lay-off notice from the employer is required),

The Plan will be the primary payor during your Pending Termination Period.

PLEASE NOTE: the Employee must be "laid-off" and must not have retired or applied for retirement – a lay-off notice from the employer is required.

If you are covered in your Pending Termination Period and the Employee *IS NOT* laid off and/or is retired or has applied for retirement YOU MUST be enrolled in Medicare Parts A & B in order to get coverage (if eligible, you will be automatically enrolled in Medicare Part A).

- **Prescription Drug Benefit Retail Fill Limitation**

If you are having difficulty getting a maintenance medication filled at a retail pharmacy, you may have reached the maximum number of allowed fills at a retail pharmacy and need to change to Allegiant Rx Mail Order.

The Prescription Drug Benefit limits maintenance medications to **one (1) fill and three (3) refills at a retail pharmacy**. Prescriptions **for a maintenance medication** that **exceed four (4) fills at a retail pharmacy must be obtained through the Allegiant Rx Mail Order** program. You can obtain the necessary paperwork from your Local Fund Office **or your physician can contact Allegiant Rx at 1-888-327-9791 for assistance.**

- **Dependent Children between the ages of 18-26**

Effective July 1, 2014, Dependent Children between the ages of 18-26 are covered under the Plan. If your Child between the ages of 18 and 26 became ineligible for dependent coverage for any reason or was never eligible for coverage in the Plan, but is currently under age 26, your Child may be enrolled in the Plan if you provide the necessary information. Please contact the Plan Office for the proper form. Normal coordination of benefit provisions will apply.

- **Annual Notice Concerning Benefits for Reconstructive Surgery after a Mastectomy**

The Plan is required to inform you that coverage is provided for the reimbursement of expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses and costs for treatment of physical complications at any stage of the mastectomy including lymphedemas. The Plan deductible, co-payments and out-of-pocket limits apply.

****Please remember to always include your Participant ID Number (TSJ number) on any correspondence sent to the Local Fund Office.****

- **Complete Your Annual Information Request Form (AIR)**

Please remember that no medical or dental claims incurred in 2017 will be paid until the completed 2017 AIR form has been received by the Plan. Prescription drug and vision care benefits will also be affected if your Local Fund Office does not have your 2017 AIR form on file. **During the year, you must notify the Plan if there is a change in the information on your AIR form.**

If you have any questions, please contact your Local Fund Office.

Board of Trustees