TRI-STATE JOINT FUND

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Important Information
Summary of Recent Changes to Your Benefits Under the Teamsters Plan

May 2021

With this notice, the Board of Trustees announces the following changes to the Plan of Benefits of the Teamsters Plan, including the ***100% COBRA Subsidy*** in the ***American Rescue Plan Act "ARPA"***. If you have any questions, please contact your Local Fund office.

Please read this notice carefully.
This notice makes you aware of 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 (as well as other reminders and notices) are also included at the end of this mailing (see below).

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

Please remember that no medical or dental claims incurred in 2021 will be paid until the completed 2021 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 2021 AIR form on file. During the year, you must notify the Plan if there is a change in the information on your AIR form.

Effective April 21, 2021, the federal government extended the COVID-19 public health emergency. That means the public health emergency will last for at least an additional 90 days, until July 20, 2021.

The following change is effective April 1, 2021:

The Pending Termination Period is Eliminated April 1 2021 for Any Participant Eligible for the ARPA Subsidy Because They Lost Coverage April 1 or After

As we are sure you know, the federal government is subsidizing 100% of COBRA premiums from April 1, to the end of September 2021 for participants (employees and dependents) who lost coverage in the Plan because of a reduction in hours or INVOLUNTARY unemployment from

November 2019 going forward. So if, you are already on COBRA, you would not have to pay your premiums for this period, as long as you remained eligible. *Such participants will receive a separate notice.*

Participants (who lost eligibility for the reasons noted above) going back to November of 2019 who did not elect COBRA (or who did elect COBRA but who did not self-pay for the full 12 months) will get a *second election period.* This second election period will allow these participants to elect COBRA beginning April 1 and they will not have to pay their premiums from April 1 to the end of September 2021, or for however long they remain eligible. *Such participants will receive a separate notice.*

Participants who lose coverage as of April 1 and after because of a reduction in hours or INVOLUNTARY unemployment – in other words, Participants who are eligible for the ARPA 100% COBRA Subsidy – will not have a Pending Termination Period. They will immediately have self-pay COBRA rights as of the date they lose coverage in the Plan. HOWEVER, from April 1 until the end of September 2021, such participants will still not have to pay anything because the government is subsidizing these COBRA premiums at 100%.

If you are one of the participants affected by the change in the Pending Termination Period, you should see no difference in your COBRA coverage – you will still not have to pay for the first six months of your COBRA coverage.

As the Plan is currently written, after you lose coverage based on eligibility, you receive a six month period of coverage known as the Pending Termination Period. This six-month Pending Termination Period is also the first six months of COBRA coverage at no cost to you. This change eliminates the Pending Termination Period for participants who lose coverage in the Plan on April 1 or after and who are eligible for the government 100% COBRA Subsidy.

- Participants who lose coverage on April 1 or after for any other reason: for instance, because they age out coverage or divorce WILL STILL HAVE A PENDING TERMINATION PERIOD.

- Participants who lost coverage as of November 2019 and who never elected COBRA, or who elected COBRA and did not self-pay for the full 12 months, or participants currently on COBRA have already had their Pending Termination Periods.

- Participants who are eligible for the ARPA subsidy who are in their Pending Termination Period as of April 1 (they lost coverage March 1, 2021 or before), will run out their Pending Termination Periods and then be offered COBRA self-pay for 12 months. These participants will be eligible for the subsidy for a portion of their self-pay period.

The following changes are effective July 1, 2021:

Vision Benefits

The non-Plan frame allowance was increased to $300.00, previously the allowance was $150.00. Non-Plan frames (outside the Davis Vision network options) must be obtained from a Davis Vision provider.

Vision benefits for spouses will be at the same level as the employee allowing a spouse to receive up to two (2) pairs of eyeglasses or contacts, or three (3) pairs in lieu of bifocals every 24 months.

Eye exams are currently covered every 12 months for both employees and spouses.

Cologuard

Cologuard will now be covered under the Plan as a preventative benefit, covered at 100%, and subject to the same medical necessity criteria that colonoscopies are currently covered. Pre-Certification will not be required. Participants will be allowed to choose Cologuard over a traditional preventative colonoscopy. If a participant tests positive, the Plan will cover a follow-up diagnostic colonoscopy **in the same calendar year**. Currently, the Plan pays the first $250.00 and the remaining balance subject to deductible and co-insurance for a diagnostic procedure. Pre-Certification is required for a traditional colonoscopy.

Telemedicine

With the outbreak of the Coronavirus, Telemedicine became the only way, in many cases to be able to access medical care. Going forward, as participants have established care through Telemedicine, the Plan will continue to cover Telemedicine beyond when the pandemic is declared over. Beyond the end of COVID, Telemedicine will be covered subject to deductible & coinsurance. Currently, Telemedicine is covered at 100%.

Inpatient Hospitalizations Related to COVID-19 covered with no Participant Cost-Sharing extended thru July 20, 2021

In response to the continued public health crisis, the Trustees have extended through July 20, 2021 the policy of covering COVID-19-related inpatient hospital costs with no Participant out-of-pocket costs. Eligible inpatient medical expenses for covered services will be paid at 100% (copayments, deductibles & coinsurance will be waived) when associated with a COVID-19 diagnosis thru July 20, 2021. Treatment must be considered medically necessary and would include hospital, physician services and prescription drug items received in the hospital for the treatment of COVID-19 conditions, provided such services are not otherwise excluded under the Plan. If a Participant is receiving inpatient care for another condition and is diagnosed with COVID-19, regular cost-sharing requirements apply to treatment for the other condition (including general inpatient charges) for which the hospitalization was originally required.

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

- **HIPAA Privacy Notice**

You and your dependents each may request a copy of the HIPAA notice of privacy practices, free of charge by contacting the Tri-State Joint Fund Office at (203) 250-2601. This notice can also be found in the Teamsters Plan Summary Plan Description booklet.

- **Grandfathered Status**

The Board of Trustees believes that the Teamsters 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 **1-203-250-2601 x109** or the **Teamsters Medical Review Program** at **1-800-888-9255** for more information.

- **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 Mail Order or the 90-day retail option using the CVS Saver Plus network program.

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 Mail Order or the 90-day retail option using the CVS Saver Plus network program**. Your physician fax can fax a prescription to 1-800-491-7997**.** If you have any questions, call 1-844-805-9802 to speak with an OptumRx representative.

- **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 Fund 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.****

Board of Trustees