TRI-STATE JOINT FUND

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Important Information
Summary of Recent Changes to Your Benefits Under the
Special Retiree Plan (SR)

November 2021

With this notice, the Board of Trustees announces the following changes to the Plan of Benefits of the Teamsters Special Retiree Plan. If you have any questions, please contact the Tri-State Joint Fund Retiree Department.

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 is included at the end of this mailing (see below).

Out-Of-Network Claims

Both in-network and out-of-network medical claims are paid based on the "**Covered Charge**" less any deductible or coinsurance that applies. For **in-network** claims the Covered Charge is the amount contained in the network provider agreements and/or other applicable agreements or schedules. **Out-of-network** claims are paid based on the **Reasonable and Customary Charge** which is determined by the Plan to be the charges normally made by providers who render or furnish such services, treatments or supplies in the same (geographic) area to individuals with an Illness or Injury of a comparable nature and severity. The Plan uses the Anthem out-of-network Allowable amount to determine the **Reasonable and Customary Charge**. This amount is sent electronically based on the type of service and where it was provided (in rare circumstances, the Plan may use negotiated rates from another ancillary repricing network to make this determination).

Please remember, out-of-network providers can bill **you** the difference between what they charge and what the Plan paid. In some cases, the amount **you** will owe the provider could be **significant**, especially for In-Patient and Out-Patient Mental Health and Substance Abuse facilities and lab testing/service-related charges. By using an in-network provider **you** can save money as well as save money for the Plan. The Board of Trustees encourages plan participants to use an in-network provider whenever possible.

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

Please remember that no medical or dental claims incurred in 2022 will be paid until the completed 2022 AIR form has been received by the Tri-State Joint Fund Retiree Office. Prescription drug and vision care benefits will also be affected if the Tri-State Joint Fund Office does not have your 2022 AIR form on file. During the year, you must notify the Tri-State Joint Fund Office if there is a change in the information on your AIR form.

The following changes are effective January 1, 2022:

Plan SR Under 65 Prescription Drug & Medical Benefit Redesign

Retirees will no longer have to pay the full cost of prescription drugs upfront! ☺
Prescription drugs will flow through the network prescription drug provider (OptumRx). You will pay your 20% coinsurance at the point of sale, until you reach the $1,000 out-of-pocket, then prescriptions will be covered at 100%. The deductible for Medical Benefits will be $250 with a $1,750 out-of-pocket (includes deductible). You will pay the 20% coinsurance until you have met the deductible and out-of-pocket maximum. Refer to the chart below:

	Current Plan SR	**Redesigned Plan SR**
Deductible	$250 medical & Rx combined	$250 medical $0 Rx
Out-of-Pocket Maximum	$2,250 (including deductible) medical & Rx combined	$1,750 medical (including deductible) $1,000 Rx
Coinsurance	20%	20%

Prescription Drug claims will not be payable if obtained out-of-network.

The Prescription Drug limits for maintenance medications at a retail pharmacy will also apply. Participants will be able to get one (1) fill and three (3) refills, after that medications **must** be obtained through the Mail Order or the 90-day retail option using the CVS Saver Plus network program. Your physician 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.

Inpatient Hospitalizations Related to COVID-19 covered with no Participant Cost-Sharing extended thru January 16, 2022, unless the Federal Government terminates the Public Health Emergency sooner or Extends it

In response to the continued public health crisis, the Trustees have extended the policy of covering COVID-19-related inpatient hospital costs with no Participant out-of-pocket costs until January 16, 2022, **or sooner if** the Federal Government terminates the Public Health Emergency or extends it. 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. 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.

Telemedicine

Telemedicine became a prevalent way to access medical care during the Public Health Emergency as Doctor's offices were closed. Slowly, Doctor's offices are re-opening allowing participants to opt for virtual or in office visits. As a result, the Plan will continue to cover Telemedicine at 100% through December 31, 2021. Effective January 1, 2022, Telehealth visits will be covered subject to deductible & coinsurance, **except** telehealth visits that result in the ordering of a diagnostic test for COVID-19.

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.

- **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.

- **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 Tri-State Joint Fund Office.****

Board of Trustees