Important Information
Summary of Recent Changes to Your Benefits Under the

Teamsters Plan E and the Teamsters Plus Plan for Plan E Active Participants and Plan E Post-Employment Benefit (PEB) Participants

May 2018

With this notice, the Board of Trustees announces the following changes to the Plan of Benefits of the Teamsters Plan E and the Teamsters Plus Plan for Plan E Active and Retired Participants.

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

The required annual notice concerning reconstructive surgery after a mastectomy and reminder to complete your **2018 Annual Information Request (AIR) Form (as well as other reminders and notices) are also included in this mailing (see below).**

The following change is effective for PEB Participants as of January 1, 2018

Maximum Period of PEB Coverage Extended

PEB coverage is extended for up to 15 years for all PEB Participants as of January 1, 2018 who retired prior to December 31, 2016. At the Spring 2017 meeting, the Trustees agreed to increase the availability of PEB from 10 years to 15 years, effective only for Plan E employees retiring December 31, 2016 or after. In order to be eligible for 15 years of PEB coverage, you would have to be or have been a PEB Participant on or after January 1, 2018.

PEB is 80% subsidized by the affiliated Plan – the former employee only pays the remaining 20% for his or her coverage in the year of retirement and this rate remains unchanged through the tenth year of PEB coverage. The rate in years 11-15 change each year and are based on the rate for new retirees in each year for years 11-15.

The following changes are effective July 1, 2018

Biofeedback

Biofeedback will now be covered when reasonable and necessary for the following:

- Re-education of muscle groups when conventional methods such as heat, cold, therapeutic massage, exercise and/or support have been unsuccessful;
- Treatment of stress and/or urge urinary incontinence when there is failure of other non-pharmacologic treatment (e.g., bladder training and/or pelvic floor muscle training [PFMT]); and
- Re-education of specific muscle groups for the treatment of:
    - Pathological muscle spasticity abnormalities,
    - Incapacitating muscle spasms, and
    - Muscle weakness.

This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions. Coverage is limited to 10 visits per year and $115 per visit and is subject to pre-certification. Biofeedback was previously excluded under the Plan.

Transgender Related Services

Medically necessary treatment for Participants diagnosed with gender dysphoria will be covered under the Plan including:

- Behavioral health services including but not limited to, counseling, psychotherapy, and related treatments for gender dysphoria and related psychiatric conditions;
- Continuous hormonal therapy;
- Laboratory testing to monitor the continuous hormone therapy;
- Age-related, gender-specific services as a precursor to gender reassignment, including but not limited to preventive health care (e.g., cancer screening [cervical, breast, prostate] and treatment of a prostate medical condition); and
- Gender reassignment surgery and related surgical procedures.

Gender reassignment surgery would have to be determined to be medically necessary in order to be covered by the Plan; in addition, the Participant seeking gender reassignment surgery must meet the following criteria:

- Have a letter of referral from a qualified/licensed mental health professional documenting and confirming the diagnosis of gender dysphoria,
- Be diagnosed with persistent and well-documented gender dysphoria,
- Have the capacity to make a fully-informed decision and to consent to treatment,
- Be 21 years of age or older, and
- Have no significant medical conditions, psychological conditions, or social concerns that could interfere with treatment, or if these conditions or concerns are present they are reasonably controlled.

Depending on the type of gender reassignment surgery, additional requirements may be necessary to qualify including:

- An additional referral letter from a qualified/licensed mental health professional, and
- 12 months of continuous hormone therapy that is consistent with the individual's gender goals.

Transgender related services were previously excluded under the Plan.

Fitness Awareness Benefit

The Fitness Awareness Benefit language was clarified as follows (changes in *italics*):

"**Fitness Awareness Program**
The Fitness Awareness Program is available to all Participants and provides a payment for participation in certain programs that may be beneficial to health. The award will be made to you upon completion of any or all of the following structured programs offered by a bona fide commercial enterprise, up to the annual maximum shown in the Schedule of Benefits:

1. Weight loss program;
2. *Gym Memberships, with consistent attendance;*
3. Exercise class*, excluding participation in a sport, martial art class or any other activity that includes or provides the opportunity for exercise as a by-product, only*;
4. Smoking cessation course; and
5. Diet and nutrition classes.

Written proof of completion of the course or program must be provided. A certificate of completion or a letter written on the letterhead of the program and signed by the instructor will be considered written proof.

Written proof of consistent gym attendance must be provided.

Limitations

No payment will be made for the completion of courses or programs:
1. Not specifically listed above;
2. That do not have an identifiable beginning and ending, with the exception of the Take Charge Program for a Healthy Heart which requires one year of participation by an individual who qualifies for enrollment;
3. Are in excess of the annual benefit allowed in the Schedule of Benefits;
4. Are in excess of actual amount incurred by Participant; or
5. Which, upon review by the Trustees, are determined not to be bona fide."

Extended Care/Rehabilitation Benefit

The Extended Care or Rehabilitation Facility Benefit language was clarified as follows (changes in *italics*):

"**Extended Care or Rehabilitation Facility**

Covered Charges for a confinement in an Extended Care or Rehabilitation Facility will be payable in accordance with the Schedule of Benefits for up to 60 days per *Injury or Illness* if:

1. You are confined as an inpatient in an Extended Care or Rehabilitation Facility within three (3) days after discharge from a Hospital; or

2. You are transferred to a unit of a Hospital primarily for rehabilitation purposes and the required treatment is due to the same cause as the previous Hospital confinement.

Reimbursement for therapies, but not facility charges, may be considered under the Major Medical benefits, upon exhaustion of the 60 day confinement period.

A successive *Injury or Illness for the employee in Covered Employment* will be considered *the same Injury or Illness* unless:

1. The subsequent *diagnosis* is entirely unrelated to the *Injury or Illness* of the previous confinement; or
2. The employee in Covered Employment has completely recovered from the Injury or Illness causing the previous confinement, or has returned to active work for at least one (1) full working day before the subsequent confinement commences.

In the case of a Spouse or Child, *Injury or Illness* will be considered *the same Injury or Illness* unless separated by an interval of six (6) months or more regardless of cause."

Pending Termination Period

The Pending Termination Period was changed to provide for a pending termination period equal to the number of months of eligibility in the Plan, up to the maximum pending termination period of six months. This change will prevent Participants from becoming eligible for coverage for a short period and then getting the advantage of six months of free coverage under the pending termination period provision of the Plan.

The following change is effective as of January 1, 2019

Dental Coverage for PEB Participants who are over 65 years old

The Plan was amended to provide $500 per year of dental coverage paid according to the active Teamsters Plus Plan dental schedule to PEB Participants who are over 65 years old.

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 new copy of the HIPAA notice of privacy practices, free of charge by contacting the Tri-State Joint Fund Office at (203) 876-3100.

- **Grandfathered Status**

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.

- **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 Express Scripts 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 Express Scripts Mail Order** program. You can obtain the necessary paperwork from your Local Fund Office **or your physician can contact Express Scripts 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 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.****

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

Please remember that no medical or dental claims incurred in 2018 will be paid until the completed 2018 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 2018 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