TRI-STATE JOINT FUND

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203-250-1232

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

May 2020

With this notice, the Board of Trustees announces the following changes to the Plan of Benefits of the Teamsters Plus Plan. 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 is 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 2020 will be paid until the completed 2020 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 2020 AIR form on file. During the year, you must notify the Plan if there is a change in the information on your AIR form.

Participants are ultimately responsible for knowing the Plan of Benefits. Please contact your Local Fund Office with questions regarding whether **expenses for services, supplies or treatment are covered under the Plan and/or if Pre-Certification is required.**

Diagnostic Testing for COVID-19 Infection Covered with No Participant Cost-Sharing

Effective immediately, the Plan will pay for any COVID-19 diagnostic testing or items and services related to such testing and no co-payment, co-insurance or deductible will apply. Whether the testing is done at your doctor's office, a clinic, or in an outpatient setting, the Plan will pay the full cost of the testing without any cost to you.

Certain Deadlines are Waived for the Period of the COVID-19 Public Health Emergency

The Plan will disregard the following deadlines from March 1, 2020 until the end of the "Outbreak Period". The "Outbreak Period" is defined as sixty (60) days after the end of the public health emergency relating to COVID-19.

- COBRA:
  - ✓ The 60-day election period for COBRA continuation coverage – normally you have 60 days from the end of your benefits (generally) to decide and elect COBRA coverage; this deadline is waived until the end of the Outbreak Period;
  - ✓ The 45-day period for making the first COBRA premium payments _ normally you have 45 days from the date you elect COBRA to make the first payment; that deadline is waived – PLEASE NOTE: your COBRA coverage still will not start until payment going back to the date you lost coverage is received;
  - ✓ The deadline for notifying the Plan of a qualifying event or determination of disability for COBRA eligibility purposes is waived.
- Claims and Appeals
  - ✓ The time frame after the date of service for filing a claim (180 days) is waived;
  - ✓ The deadline for filing an appeal of an Adverse Benefit Determination (180 days) is waived;

In addition, for your information, the Plan's duty to provide a COBRA election notice when you have a qualifying event is also waived during the Outbreak Period. However, please note that the Plan intends to continue to follow all established COBRA parameters.

Inpatient Hospitalizations Related to COVID-19 covered with no Participant Cost-Sharing

Eligible inpatient medical expenses for covered services will be paid at 100% (copayments, deductibles & coinsurance would be waived) when associated with a COVID-19 diagnosis for the period January 1, 2020 thru December 31, 2020. 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.

We hope that you and your families are staying safe, and you are following the suggestions from the CDC and other government agencies regarding handwashing, "social distance," and following your local authorities' rules about public gatherings.

Continuous Glucose Monitoring Systems (GMS)

The GMS benefit was amended to comply with the new prescription drug network's (OptumRx) guidelines and how OptumRx provides the devices and related supplies. The age restriction was removed (previously GMS was available to Participants age 18 or older), and the reader, transmitter, receiver and sensors will be replaced according to the manufacturer's guidelines (previously a reader would be replaced every two years). Also, eligibility for the GMS systems will be approved by Optum Rx (previously the Local Fund Office or the Tri-State Joint Fund Office).

The following changes are effective July 1, 2020:

Increase Life Insurance & AD&D Benefit for Spouse & Dependents

The Life Insurance benefit and the base for the Accidental Death & Dismemberment benefit has been increased from $3,000 to $10,000 for Spouses and from $1,000 to $5,000 for dependents of eligible employees in Covered Employment, only.

Coverage for Continuous Positive Airway Pressure (CPAP) Cleaning Machines

A Participant who received a CPAP machine within the last five (5) years is eligible to purchase a CPAP cleaning machine. Upon submitting the receipt of purchase to your Local Fund Office, the fund will reimburse up to $300.00 (excluding sales tax) of the purchase price. CPAP cleaning machines will be covered once every six (6) years.

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 Plus Plan Summary Plan Description booklet.

- **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 **1-203-250-2601 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