MOVING & STORAGE AND TRADE SHOW INDUSTRY SUMMARY PLAN DESCRIPTION

Teamsters Union 25
Health Services & Insurance Plan
www.teamsterscare.com

A Letter from the Board of Trustees

To All Eligible Participants in the Moving & Storage and Trade Show Industry Program:

The Board of Trustees is pleased to provide you with this Answerbook…an updated description of your TeamstersCare benefits. The benefits described in this booklet, although authorized by the Trustees and administered by our TeamstersCare staff, are benefits that you have earned—and continue to earn—over the course of your working years.

The Trustees are committed to providing you and your eligible family members with high-quality health care coverage as well as weekly disability and other benefits.

Besides these basic coverages, you and your family have access to local TeamstersCare in-house clinical services at our Charlestown, Chelmsford and Stoughton facilities. Services include the Employee Assistance Program (EAP), prescription drug, dental, and hearing care services in supportive surroundings at the hands of our own dedicated TeamstersCare healthcare professionals.

Your new Answerbook is a **Summary Plan Description (SPD),** which is a document designed to outline the basic details of your TeamstersCare benefits. The Board of Trustees is the Plan Sponsor and Plan Administrator of the benefits according to the terms of this SPD and the Agreement and Declaration of Trust of the Teamsters Union 25 Health Services & Insurance Plan.

The Answerbook describes the benefits and services available if you or one of your eligible dependents is sick or injured, needs preventive care, or suffers an unexpected loss. Please read this booklet carefully and make certain your family understands how they can use the Answerbook to find important information, both routinely and in case of emergency.

If you have questions on any aspect of your benefits, visit us in person at one of our facilities, check our website at **www.teamsterscare.com** or contact TeamstersCare through Charlestown Member Services at the following numbers:

local: **1 (617) 241-9220**, ext 2

toll free in MA: **1 (800) 442-9939**, ext 2

toll free outside MA: **1 (800) 225-6135**, ext 2

Remember:

No question you or a dependent may have is too basic to ask— or too much trouble for us to answer.

Sincerely,

Board of Trustees

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Introduction

The **Teamsters Union 25 Health Services & Insurance Plan,** more commonly called **TeamstersCare,** offers you and your family the security of quality health care and a measure of financial protection through disability, life, and accident insurance plans.

If you're an eligible TeamstersCare member in the **Moving & Storage and Trade Show Industry Program,** you, your spouse, and your dependent children have the following health benefits:

- medical care and hospitalization
- behavioral health benefits
- pharmacy and prescription drugs
- dental care
- vision care
- hearing care
- employee assistance program (EAP)

As a member, you also have the additional financial protection provided by these TeamstersCare benefits:

- weekly disability benefits—replacement income if you can't work because you're sick or injured—for the member
- life insurance —for the member and dependents
- accidental death and dismemberment (AD&D) insurance—extra life and accident protection—for the member

Certain Collective Bargaining Agreements (CBAs) may provide different benefits. If you are covered under one of these agreements, you'll receive additional information specific to your benefits.

As a reference, this booklet contains quite a bit of detail about your benefits. You should share the information in this booklet with your family.

If you have questions regarding specific benefits that you can't find described in this benefit booklet, don't hesitate to call Charlestown Member Services. See page 76 for these and other important phone numbers.

The Patient Protection and Affordable Care Act

In March 2010, Congress passed and the President signed into law the Affordable Care Act. As a result of the Act, TeamstersCare is required to provide you with certain health care coverages and information.

Grandfathered Plan under the Affordable Care Act

TeamstersCare believes that our plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered plan means that TeamstersCare may not include certain consumer protections of the Act that apply to other plans. For example, we are not required to follow the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, such as the elimination of lifetime dollar limits for benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause the plan to change status can be directed to the TeamstersCare Executive Director, at (617) 241-9220 ext. 244. You may also contact the Employee Benefits Security Administration, US 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.

Eligibility

Member Eligibility

You become eligible for TeamstersCare benefits in one of two ways:

- You begin working for an employer who is already participating with Teamsters Local 25 (or some other participating Local or organization) and who is contributing to Teamsters Union 25 Health Services & Insurance Plan (TeamstersCare)—in this case, you become an active participant as soon as you fulfill the eligibility requirements

  or

- You are already working for an employer who begins participating with Teamsters Local 25 (or some other participating Local or organization) and begins contributing to TeamstersCare—in this case, you become an active participant when your employer contributes to TeamstersCare an amount equal to the remittance rate times the required number of hours and you fulfill the eligibility requirements.

How You Become Eligible

To become eligible to enroll in benefits once you're covered by a contract requiring contributions on your behalf, you have to work and your employer must have remitted contributions for a total of 550 or more hours during a fixed six-month eligibility determination period. To be eligible for coverage for the period February 1 through July 31, you must have a minimum of 550 hours contributed on your behalf in the previous June 1 – November 30 period. To be eligible for coverage for the period August 1 through January 31, you must have a minimum of 550 hours contributed on your behalf in the previous December 1 – May 31 period, as follows:

Eligibility Determination Period	**Benefit Coverage Period**
A minimum of 550 hours credited in:	*Gives coverage in:*
June - November	February - July
December – May	August - January

There is no provision for you to buy-in or purchase hours if you have less than 550 hours contributed on your behalf during an eligibility determination period.

- ***Important Note:*** In this Answerbook, anytime the word "work" is used as it relates to eligibility, it means credited with required contributions according to the Collective Bargaining Agreement or by law. In this context, "required contributions" means contributions owed to the Fund for those hours– or part of hours–for which wages are paid or due figured to the nearest quarter hour, as well as hours for paid vacation, paid holiday, and other hours for which pay is due or received by the member.

Dependent Eligibility

When Your Dependents Are Eligible

Once your own eligibility begins, your dependents also become eligible for TeamstersCare medical, prescription drug, dental, vision, hearing, and behavioral health benefits.

Important Note: ***For purposes of TeamstersCare eligibility, once your dependent is enrolled, and as long as your dependent meets the Plan's definition of "eligible dependent," you cannot terminate coverage for that dependent, except in the case of an adult dependent with other coverage. Contact TeamstersCare Member Services for details.***

"Eligible dependents" include:

- your current spouse, or an ex-spouse who was covered by the Plan when you divorced, or an ex-spouse who was an eligible and enrolled dependent in your previous health plan when a new employer begins contributing to the Plan, in cases where:
  - you have a divorce decree requiring you to cover your ex-spouse, and
  - you decline coverage for your current spouse (in order to maintain coverage for your ex-spouse) and your current spouse agrees in writing to waive coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other coverage. Important Notes: New members working for a regular contributing employer cannot cover an ex-spouse if the member was divorced or legally separated before joining the Plan. Under the Plan, you cannot cover a spouse and an ex-spouse at the same time.
- your children, up to the last day of the month in which the child turns age 26
- your unmarried children who are incapable of self-care because of a physical or mental disability. (See Defining "Disabled Children").

Defining "Eligible Children"

"Eligible children" include your natural children; dependent children of your dependents; legally adopted children; children placed with you for adoption; stepchildren (note that if you divorce, your former stepchildren are no longer considered eligible dependents); children for whom the member has been appointed legal guardian; and foster children. TeamstersCare also covers a member's children named under a Qualified Medical Child Support Order, provided a copy of this order is filed with Teamsters Union 25 Health Services & Insurance Plan, 16 Sever Street, Charlestown, MA 02129-1305. Call Charlestown Member Services at (617) 241-9220 ext 2 for a copy of TeamstersCare's procedures regarding Qualified Medical Child Support Orders.

Defining "Disabled Children"

Under certain circumstances, TeamstersCare may continue to provide medical benefits for a disabled child beyond the date dependent eligibility would normally have ended. For coverage to be extended, the child must be first disabled before they turn age 26 and, at that time, they must be:

- covered by the Plan
- currently unmarried, and

— mentally or physically disabled so as not to be able to earn his or her own living on the date eligibility would normally end.

In order for your dependent to be eligible for continued medical coverage, you must provide TeamstersCare with proof of the disability within 30 days after the disabled child turns 26.

TeamstersCare will help you with required documentation and coordinating with benefit vendors. From time to time you may be required to provide updated information. For further details, contact Charlestown Member Services at 617-241-9220, ext. 2.

Important Note: ***If you have a disabled dependent when you—as a member—first become eligible for TeamstersCare coverage, the Plan may provide medical benefits for that dependent so long as you submit proof of disability to TeamstersCare Member Services within 30 days of the date you become eligible.***

Continuing TeamstersCare Coverage

Continuing TeamstersCare Coverage under COBRA

In certain cases where you or your dependents would otherwise lose healthcare benefits, you may be able to continue medical coverage under the Federal law known as COBRA (see page 46 for details on COBRA coverage).

Dependent Coverage when Eligibility Ends

Your dependents lose coverage at the same time your own eligibility ends. Individual dependents can also lose coverage if they no longer meet the definition of an eligible dependent; however they may be able to continue medical coverage through COBRA (see page 48 for details on COBRA coverage for dependents).

Family Coverage in Case of Your Death

If you die while covered by the TeamstersCare Program, TeamstersCare will continue to provide your family with medical, behavioral health, prescription drug, dental, vision, hearing, and the Employee Assistance Program for a period of time. Their benefits can last until the end of the benefit coverage period for which you had qualified. At the end of the coverage period, your family will have the option of continuing coverage under COBRA. When extending benefits under any of these options, certain conditions may apply. For more information, call Charlestown Member Services at (617) 241-9220 ext 2.

Continuing Coverage if You're Disabled

If you're disabled and are receiving either TeamstersCare Weekly Disability benefits (for a non-work-related disability) or Workers' Compensation (for a work-related disability), you may be able to continue receiving TeamstersCare medical benefits during the period of your disability. In either case, you must meet all of the Plan's eligibility rules.

If your disability is caused by a job-related sickness or injury and you're receiving Workers' Compensation benefits, your employer may be required to contribute to TeamstersCare at a rate of 32 hours per week for up to 12 months, if specified in your Collective Bargaining Agreement (CBA).

Continuing Coverage for Your Spouse after Legal Separation or Divorce

In the event of divorce or legal separation, a court might order you to provide medical coverage for your former spouse and eligible dependents. In certain cases, TeamstersCare may extend the same coverage to which your ex-spouse had been previously entitled, except for life insurance. To be eligible, your ex-spouse must have been covered by the Plan at the time of your divorce. You will need to provide Charlestown Member Services with the effective date of the divorce and documentation of the court order within 30 days of your divorce becoming final.

If coverage is extended, but your ex-spouse subsequently remarries, then the extended coverage ends on the date of remarriage. You, as the member, are responsible for notifying TeamstersCare within 31 days of this change in family status. If you remarry, you may elect to continue coverage for your ex-spouse—instead of your new spouse—provided your new spouse agrees in writing to waive coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other health coverage. Under the Plan, you cannot cover a spouse and an ex-spouse at the same time.

If, upon divorce, you are not required to provide coverage for your ex-spouse, he/she may be eligible to purchase temporary extended healthcare coverage under COBRA for up to 36 months (see page 48 for details of COBRA coverage for dependents).

You, as the member, are responsible for notifying an ex-spouse of all benefit information including benefit changes, reinstatements, providing ID cards, etc. The Plan is responsible for notifying an ex-spouse of COBRA coverage upon termination of health care benefits.

Important Note: ***Divorce or legal separation is a change in family status, which—in order to ensure coverage for your eligible dependents—you must report to TeamstersCare within 31 days of the change. If you fail to do so, TeamstersCare cannot ensure continuous or timely coverage for any claims incurred beyond that 31 day period. Furthermore, you the member are responsible for any claims incurred by an ineligible dependent.***

Coverage on Returning from Military Duty

If you return to your job within 90 days of authorized military duty, your TeamstersCare coverage is reinstated immediately, provided:

- you were eligible for benefits at the time you went on duty
- you work at least one hour for a contributing employer after returning to work
- your employer provides TeamstersCare with documentation that you have returned to work, and
- you provide proof of military service listing your discharge date

Your reinstated coverage continues for the remainder of the eligibility determination period during which you were reinstated through the subsequent benefit coverage period, according to the following schedule:

Eligibility Determination Period	Benefit Coverage Period
June through November	February through July
December through May	August through January

For example, if you return to work on August 20th, and work at least one hour, then coverage for you and your eligible dependents begins on August 20th and continues through July 31st.

While you are in the military, you and your dependents have the right to elect continued benefit coverage under COBRA for up to 24 months (see page 46 for details on COBRA coverage).

Coverage through Medicaid and the Children's Health Insurance Program (CHIP)

If you are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1 (877) KIDS-NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Visit the TeamstersCare website at **www.teamsterscare.com** for a list by state with contact information for the Medicaid and CHIP Offices.

How to Enroll in TeamstersCare Benefits

Information You Must Provide to Enroll in TeamstersCare Benefits

Once you are eligible, in order to enroll in TeamstersCare benefits, we must have complete, accurate, and up-to-date information for you and your eligible dependents. You are responsible for providing this information and for keeping the information updated.

Once you have worked the required number of hours and your employer has made the corresponding contributions, Charlestown Member Services will send you an Enrollment Package. You must complete the Enrollment Form and return it to Charlestown Member Services with supporting documentation (i.e. marriage license and a birth certificate for each dependent child) within 31 days of receiving the package.

Important Note: ***TeamstersCare cannot activate your benefits, which means you and your family will not have access to TeamstersCare coverage, until we have received a complete and accurate Enrollment Form and corresponding documentation. If the Enrollment Form is not received within 31 days from when we send the package, eligibility for benefits will be activated on the first day of the month in which the Enrollment Form and documentation is received.***

Change in Family Status Notification

A change in family status is any event that affects the records we currently have on file for you and your dependents. This includes, but is not limited to, the following:

- moving out of the geographic area covered by your medical option (i.e., you and/or your dependents permanently move outside of New England)
- a change in your address or the address of an eligible dependent

- marriage, divorce or legal separation, or the mandate of a court order
- adding a new dependent by: birth, adoption, or placement for adoption; marriage; the mandate of a Qualified Medical Child Support Order (QMCSO)
- death of an eligible participant
- loss of dependent eligibility; change in physically or mentally disabled status
- returning to work after a disability
- any change in your own or your dependent's employment-related healthcare coverage
- eligibility for Medicare and/or Social Security disability status
- coverage for you and/or any of your dependents under any group benefit plans other than TeamstersCare

Important Note: ***If you have a change in family status you—or someone acting on your behalf—must notify Charlestown Member Services by telephone or in writing within 31 days of the change (see page 76 for contact information). If you fail to do so, TeamstersCare cannot ensure continuous or timely coverage of any claims incurred beyond that 31-day time period. TeamstersCare may require that you submit certain changes in writing or proof of your change in family status when you notify us of a change.***

TeamstersCare manages all eligibility and enrollment issues. Anytime you provide us with eligibility-related information, we provide notification to all of the benefit vendors on your behalf.

Suspension of Benefits

There are certain instances where, although you may be otherwise eligible for TeamstersCare benefits, your benefits and those of your dependents could be suspended until such time as the situation causing your suspension is remedied. A member's suspension could result from:

- not responding to a request to repay an overpayment of a disability claim
- not repaying a lien after you receive a monetary award
- not repaying the Plan after you have received proceeds from a third party
- not responding to a request for information
- not submitting an Enrollment Form or corresponding documentation when TeamstersCare requires you to do so
- enrolling an ineligible dependent
- committing fraud or misrepresenting information to TeamstersCare
- a check for a COBRA premium or TeamsterShare payment is returned from your bank as unpaid

A member whose benefits are suspended on the date a qualifying event is sustained will not be entitled to elect COBRA coverage.

TeamstersCare Benefits

Medical Benefit

TeamstersCare provides medical benefits through an HMO and a PPO (Out of Area) Option:

- TeamstersCare HMO Blue New England Option
- TeamstersCare Blue Care Elect Preferred Out of Area Option

Both of these options offer a wide range of health services, including coverage of doctor's office visits, hospitalization, surgery, maternity care, behavioral health—and many other medical products and services.

Your coverage depends on where you live. To participate in the HMO, you must live within the HMO's network service area (in this case, inside of New England). If you or any one of your eligible dependents **permanently** lives in an area not covered by the HMO, then you and all of your dependents will automatically be covered by the TeamstersCare Blue Care Elect Preferred Out of Area Option. You cannot elect the Out of Area Option if you and all your eligible dependents permanently reside in the TeamstersCare HMO Blue New England service area.

As a participant in TeamstersCare HMO Blue New England, you will need to select a Primary Care Physician (PCP) for yourself and for each covered family member. Your individual PCP will coordinate all of your routine care and guide you through any referrals you may need for specialized services. If you're a member of the Out of Area Option, you do not have to select a PCP. When you use a participating in-network provider, the Out of Area Option covers most services in full, after you make certain copays. If you use a non-network provider, most expenses are covered at 80% of reasonable and customary amounts after a $250 per individual/$500 per family annual deductible. The non-network calendar year coinsurance maximum is $1,000 per individual/$2,000 per family.

If you're currently enrolled in TeamstersCare's HMO Blue New England, and you or an eligible dependent **permanently** moves out of the HMO's service area, or you are enrolled in the Blue Care Elect Preferred Out of Area Option and you and all your dependents permanently live in the New England area, then you must call Charlestown Member Services to discuss changing your medical benefit option.

The only exception to this rule is if a dependent (for example a college student) temporarily moves out of the HMO service area. In this case, your dependent will continue to be covered by your HMO option.

TeamstersCare HMO Blue New England

Please refer to your HMO Booklet for specific details of your HMO coverage. In general:

- You'll select a Primary Care Physician (PCP)—the individual professional who is principally responsible for coordinating your medical care. Check online at **www.bcbsma.com** for physicians in your area. Your current doctor may already be a PCP in the Blue Cross network.
- Each of your family members chooses a PCP and receives medical care from his or her individual PCP.
- When specialized care is needed, your PCP coordinates all referrals to practitioners within the HMO network. It's especially important to be in contact with your PCP.

- Except for life-threatening emergencies—and other specific circumstances, HMOs pay benefits for services only when provided or referred by an individual's PCP.
- HMOs will not cover the expense of any non-emergency services you receive outside the HMO's network.
- You do not have to pay deductibles or coinsurance or fill out claim forms—though in most cases you will be responsible for making a copay.

Important Notes:

- ***If you're a new Plan member, your HMO coverage begins on the date you become eligible to enroll for TeamstersCare benefits as long as we receive your completed Enrollment Form and documentation within 31 days of the date we send your Enrollment Package. Your eligible dependents are covered as of that same date unless you enroll a dependent at a later date.***
- ***If the Enrollment Form is not received within 31 days of the date we send your package, eligibility for benefits will be activated on the first day of the month in which the Enrollment Form and documentation is received.***

TeamstersCare Blue Care Elect Preferred Out of Area Option

If you and/or at least one of your eligible dependents **permanently** reside outside the HMO's service area, TeamstersCare provides your basic medical coverage through Blue Care Elect Preferred. For more details on the Blue Care Elect Preferred provider network and facilities, call **1 (800) 810-2583** or visit **www.bluecross.com.**

When you or a dependent receives covered medical services from a Blue Care Elect Preferred provider, in most cases your only cost will be the copay that you make directly to your provider.

Non-Network Medical Coverage under the Out of Area Option

If you do not have convenient access to a Blue Care Elect Preferred provider, you can go to any other non-network provider of your choice. In this case, TeamstersCare will pay 80% of reasonable and customary costs for covered services, after a $250 individual/$500 family annual deductible, and you will be responsible for the balance (your out-of-pocket coinsurance payment). Your non-network calendar year coinsurance maximum is $1,000 per individual /$2,000 per family. (These are the maximum amounts you will pay out of your pocket each year.)

If you're a new Plan member, your Out of Area coverage begins on the same date that you become eligible for TeamstersCare coverage. Your eligible dependents are covered as of that same date. TeamstersCare must have a completed Enrollment Form and required documentation before your benefits can be activated.

If you change to the Blue Care Elect Preferred Out of Area Option due to a qualifying event, then your coverage in this option begins the first of the following month after you notify us.

For more information on specific coverages under the Blue Care Elect Preferred option, claims-related questions, and limitations that might apply to services, call the Blue Care Elect Preferred Plan at **1 (800) 241-0803**.

Blue Cross Blue Shield Behavioral Health Benefit

Counseling and treatment are available for emotional difficulties, mental illness, substance abuse, family and marital problems, childhood and adolescent concerns. Benefits also include a variety of programs and services with case managers available to help members living with chronic behavioral health conditions.

To access outpatient behavioral health services, no referral or pre-authorization is necessary; you simply make an appointment to see any **in-network provider** and pay a $15 copay for services.

For new episodes of outpatient care, up to the first 12 visits are automatically authorized. If more than 12 visits are needed, your in-network provider will contact Blue Cross Blue Shield for additional authorization, with no action needed by you.

If you experience a behavioral health emergency situation or are in need of acute hospital care, you can work with your provider to determine an appropriate plan of care; when that's not practical, you should proceed to any Emergency Room. No authorization is needed for emergency care, and if a hospital admission is necessary, the facility will contact Blue Cross Blue Shield for authorization.

Members and dependents can call the Blue Cross Behavioral Health Coordination line at 1-800-444-2426 (the phone number is listed on your I.D. card) and a Blue Cross Member Service Associate will assist you. You can also access their website at **www.bcbsma.com** and go to the Find-A-Doctor directory to locate a provider.

Important Note: ***Regardless of which TeamstersCare Medical Option you enroll in, your pharmacy, dental, vision, hearing care, and Employee Assistance Program services, are identical and provided to you through TeamstersCare, not through the HMO or the Out of Area Option.***

Clinical Benefits

Your family has access to a variety of important healthcare services provided directly by TeamstersCare through its own dedicated facilities or through specialized providers.

These services include:

- pharmacy and prescription drugs
- dental care
- vision care
- hearing care
- employee assistance program (EAP)

Important Note:* *These services are made available to you through TeamstersCare—not through the BCBS HMO or the Out of Area Option.

Pharmacy Benefits

Under the TeamstersCare plan, you and your eligible dependents have four options when you need prescription drug services.

Option #1: TeamstersCare In-House Pharmacies

The TeamstersCare Pharmacies at Charlestown and Stoughton dispense prescriptions (for up to a 90 day supply) for you and your family for a $5 (generic)/$15 (brand name) TeamsterShare Payment per prescription. The TeamstersCare in-house pharmacies offer you an easy, cost-effective way to fill prescriptions, including those you use on an ongoing basis, such as heart or blood pressure medication and diabetic supplies.

To have a prescription filled by the TeamstersCare Pharmacies, you may:

- take your prescription to the TeamstersCare Pharmacy in Charlestown or Stoughton
- have your doctor call in the prescription to the TeamstersCare Pharmacy
- have your doctor fax or e-prescribe the prescription to the TeamstersCare Pharmacy
- ask the TeamstersCare Pharmacist to call your doctor on your behalf

Refilling Your Prescription at TeamstersCare is Easy

TeamstersCare provides you with several easy options to refill your prescriptions at our in-house pharmacies.

1. **iRefill** … Download the iRefill App to your mobile device for the fastest and easiest way to refill and manage your prescriptions. You can refill your prescriptions at the Charlestown or Stoughton TeamstersCare Pharmacies anytime, anywhere, on the go. The App is available for iPhone, iPad and Android smartphones and tablets.

   For detailed instructions to install and start-up iRefill, visit our website at www.teamsterscare.com or contact one of our TeamstersCare Pharmacies.

2. **Go online using Refill Netmanager** … available to refill your prescriptions at either of our TeamstersCare Pharmacies. Simply go to www.teamsterscare.com, and click on Benefit Providers/Pharmacy, follow the prompts to the TeamstersCare Pharmacies until you locate the **Refill Netmanager** system where you can complete the Online Prescription Refill Form. Be sure to have your old prescription available, as you will need the 6 digit refill number.

3. **Call ahead using Telemanager** … an automated telephone system, available to refill a prescription at the Stoughton (781-297-9764) or Charlestown (617-241-9024) TeamstersCare Pharmacy. Simply follow the phone prompts and use the keypad on your telephone to submit the information required to refill a prescription. Be sure to have your old prescription available, as you will need the 6 digit refill number.

Please note that the hours of operation for our two TeamstersCare in-house Pharmacies are slightly different. **The hours are subject to change**.

Charlestown hours: Walk-in Service

- Monday through Thursday 8:00 a.m. to 6:00 p.m.
- Friday and Saturday 8:00 a.m. to 4:00 p.m.
- Local phone: (617) 241-9024 Toll free: (800) 235-0760
- Fax: (617) 241-5025

Stoughton hours: Walk-in Service

- Monday, Tuesday, Thursday, Friday & Saturday 8:00 a.m. to 4:00 p.m.
- Wednesday 8:00 a.m. to 6:00 p.m.
- Local phone: (781) 297- 9764
- Fax: (781) 297-9370

Call ahead whenever possible so your prescription will be available and ready when you arrive.

Option #2: Mail Order Prescription Service

You can have your long-term and maintenance medications filled by mail from the Express Scripts/Medco Pharmacy. The Express Scripts/Medco Pharmacy will mail up to a 90 day supply via UPS or U.S. mail for a $5 (generic)/$15 (brand name) copayment. Effective April 2012, Medco is a part of the Express Scripts family of pharmacies.

- To get started, complete an Express Scripts/Medco Pharmacy mail order form and submit it with your prescriptions.
- You can register at www.express-scripts.com to
  - view plan information
  - use MY RX Choices to compare prices on-line
  - quickly refill your mail order prescriptions
  - enroll in e-checks payments

For more information or to speak with an Express Scripts/Medco Specialist Pharmacist, call Express Scripts/Medco Member Services toll free at 1 (877) 543-7097.

Option #3: Use your Express Scripts/Medco Prescription Drug card at an Express Scripts Network Pharmacy

You can use a retail network pharmacy—but you'll have to pay a higher copay and, in some instances, coinsurance. You are limited to the lesser of a 30 day supply or 100 units. (See page 23 for a Prescription Drug Costs Chart detailing drug costs at a retail network pharmacy.)

- Generic Medication: **$10 copay** …up to a 30 day supply
- Brand Name Medication, when no generic is available: **$20 copay** …up to a 30 day supply
- Brand Name Medication, when a generic is available: **$20 copay, plus the difference** between the cost of the brand name and generic ...up to a 30 day supply

Walgreens, Sam's Club and Walmart are not part of the TeamstersCare/Express Scripts pharmacy network.

Option #4: Non-Network Retail Pharmacies

You can use a non-network retail pharmacy, but you'll be required to pay the full cost of your prescription at the point of sale, including the appropriate copay. You should then submit a claim form within 12 months—accompanied by an itemized receipt listing the amount paid— to: Express Scripts/Medco, PO Box 14711, Lexington KY 40512. Express Scripts/Medco will send you a check for the Plan's share of the cost based on the retail network rate, less the amount of your copay.

Generic vs. Brand

You will **pay less for a generic** prescription than for a brand name. Be sure to **ask your doctor**, whenever you get a new prescription, if the prescription is a generic. If it's not, ask if there's a **generic alternative** available that might work just as well for you. In some states retail pharmacies don't always make generic substitutions, particularly if the pharmacy doesn't have a generic on hand.

As a way of holding down Plan costs—and your costs as well—TeamstersCare pharmacies and the Express Scripts/Medco mail order pharmacy will fill prescriptions for brand name drugs only when there is no generic equivalent for a given medication. If a generic equivalent for your prescription exists, but you want the brand name, you'll have to go to a retail network pharmacy, or to some other non-network retail pharmacy. In either case, you'll need to pay some share of the cost. Therapeutic generic alternatives are now available for virtually every major class of brand name medication.

New Maintenance Medication at our In-house Pharmacies

Available only at the TeamstersCare Walk-in Pharmacies— When a new maintenance medication is prescribed, usually for 90 days, it may not work as anticipated. You may choose to receive up to a 30-day supply at no cost to you. If the medication works for you, you then fill the balance of the prescription, up to a 60-day supply, for a $5 (generic)/$15 (brand name) TeamsterShare Payment. If the medication doesn't work for you and your doctor switches you to another dosage or prescribes a new medication, you have saved the TeamsterShare Payment for the initial prescription.

Medications Requiring Prior Authorization

Some medications require Prior Authorization (PA) before coverage is provided. The drug's prescribed use is evaluated against certain criteria. Ask one of our TeamstersCare Pharmacy staff about the process for obtaining a medication PA. In most cases, your doctor will have to fax a completed PA Form to TeamstersCare at (617) 241-5025 with certain information needed to make a determination. Forms are available on our website **www.teamsterscare.com** or at our TeamstersCare Pharmacies.

The list of drugs requiring Prior Authorization is subject to change. The following are examples of medications that currently require prior authorization:

- Avonex
- Belviq
- Botox
- Copaxone
- Growth Hormone
- Naltrexone
- Prolia
- Simponi
- Testosterone

A more extensive list is available on our website **www.teamsterscare.com.**

Important Note: New drugs are introduced into the marketplace daily. As the FDA approves new drugs for use in the United States, TeamstersCare will assess the feasibility of covering these drugs and consider the applicability of any restrictions and/or limitations.

Specialty Medication Program

TeamstersCare has a **dedicated program for specialty medications**. These are complex medications that treat serious health conditions and may require intensive monitoring. A list of these medications is available on our website **www.teamsterscare.com** or by asking a TeamstersCare Pharmacist.

These "specialty medications" are available at TeamstersCare Pharmacies for pick-up or through Accredo Specialty Pharmacy (mail-order only). These medications require a $15 copay for each 30-day supply. They are not available at retail pharmacies.

If you use the Accredo Specialty Pharmacy to fill your prescription, they will monitor the shipment of your medication, contact you via telephone to be sure you will be home to accept the shipment, and they will be available for consultation regarding your medication 24 hours a day, 7 days a week. You or your doctor can reach them by telephone at 1 (877) 543-7097.

Prescription Drug Costs Chart

If your prescription is written for:	You Pay:	The Plan Pays:
…at Charlestown and Stoughton TeamstersCare Pharmacies (up to 90 day supply) …at Express Scripts/Medco Pharmacy mail order (up to 90 day supply)		
generic medication	$5	100% of the remaining cost
brand name medication—and no generic is available	$15	
brand name medication—and generic is available	this option not available at TeamstersCare in-house Pharmacies or mail order	
…at a Retail Network pharmacy (up to 30 day supply)		
generic medication	$10	100% of the remaining cost
brand name medication—and no generic is available	$20	
brand name medication—and generic is available	$20 + cost difference between brand name & generic	100% of the remaining cost for the generic
…at a Non-network retail pharmacy		
When you use a non-network pharmacy, you pay the full amount of your prescription at the point of sale, including the appropriate copay. Then, within 12 months of the sale date, you submit a claim form and itemized receipt to Express Scripts/Medco. They will send you a check, based on the retail network rate, less the amount of your copay.		

Prescriptions Covered

In general, TeamstersCare provides prescription drug benefits that are "medically necessary". This means that the product or service must:

- be essential for the diagnosis or treatment of the sickness or injury for which it was prescribed
- meet generally accepted standards of medical and pharmaceutical practice
- be ordered by a physician or authorized practitioner acting within their normal scope of practice

Prescriptions Not Covered

Below are some examples of prescriptions that are not covered by TeamstersCare:

- Minoxidil—or other treatments for hair loss
- Suboxone and Subutex
- Relenza
- medication for cosmetic use
- experimental medications
- experimental use of approved medications
- medication covered by Workers' Compensation, in cases where your illness or injury is work-related
- prescriptions older than one year from the date originally prescribed

- immunization agents, certain vaccines, blood or blood products
- illegal drugs
- any of the following, unless dispensed from our TeamstersCare Charlestown or Stoughton Pharmacies or Accredo Specialty Pharmacy
  - injectibles
  - tretinoin (Retin A)
  - growth hormone
  - diabetic supplies (test strips, lancets, etc.)

For a complete list of medications not covered, call a TeamstersCare Pharmacy (see page 77 for contact information or visit **www.teamsterscare.com**.)

Prescription Medication Limitations

TeamstersCare reserves the right to limit covered therapies and deny coverage for specific medications. Examples are:

- Cialis, Levitra and Viagra (6 tablets per 30 days)
- Ambien, Lunesta (20 doses per 30 days)

At your request, TeamstersCare Pharmacies will provide you with the list of medications that the Plan limits or does not cover, or medications that require prior authorization. You may also view the list at **www.teamsterscare.com**.

Dental Benefits

Under the TeamstersCare Plan, you and your eligible dependents have three basic options when you need dental care.

Option #1: TeamstersCare Dentists. You can use our in-house Charlestown, Chelmsford, or Stoughton, MA facilities for your dental treatment—with no claim forms to file. Preventive visits are available at no cost to you. You make a TeamsterShare Payment of $5 for filling visits and $10 for denture, root canal, and extraction visits.

Option #2: Dentists in one of the Dental Blue Freedom networks. TeamstersCare has an agreement with Blue Cross Blue Shield of MA (BCBSMA) which provides three networks of “private” dentists who accept discounted fees. When you use one of the Dental Blue Freedom networks, you have to pay part of the cost, and the dentist will file the claim.

Option #3: Non-Network Dentists. You can use any “private” dentist you like. Again, you’ll have to share the cost (generally, higher than Dental Blue Freedom network dentist costs), and you may be required to file a claim.

Option #1: TeamstersCare Dentists

You and your family have a convenient option for basic dental services: complete access to our TeamstersCare Dental Offices in Charlestown, Chelmsford, and Stoughton. When you go to a TeamstersCare Dental Office, you pay nothing for preventive care visits. You make a TeamsterShare Payment of $5 for filling visits and $10 for denture, root canal, and extraction visits.

TeamstersCare Dental Offices are staffed by licensed dentists, hygienists, and dental assistants. Some of our TeamstersCare dentists are on staff at Tufts and Boston University Dental Schools.

Services Provided at TeamstersCare In-house Dental Offices

The following general services are available at our three TeamstersCare Dental Offices:

- dental examinations and x-rays (preventive)
- fluoride treatment (preventive)
- cleaning and scaling (preventive)
- sealants
- fillings—amalgam and composite (silver and white)
- root canals—limited to front six upper and front six lower teeth
- simple extractions—limited to loose primary or permanent teeth
- dentures—full or partial, no more frequently than once every five years
- denture repair and reline
- mouthguards
- certain space maintainers
- second opinions
- emergency care during office hours—so long as the evaluations and treatment of dental problems are within the scope of the services provided at our TeamstersCare Dental Offices

Making Appointments

Dental Office Hours

- Monday through Thursday—Open 8 a.m., some evening appointments until 8 p.m.
- Friday and Saturday—8 a.m. to 4 p.m.

To make an appointment, call the TeamstersCare Dental Office you plan to visit, using one of the following numbers:

Charlestown

- local: 617-241-9220 , ext 1
- toll free within Massachusetts: 800-442-9939
- toll free outside Massachusetts: 800-225-6135

Chelmsford

- local: 978-256-9728
- toll free: 800-258-2111

Stoughton

- local: 781-297-7360
- toll free: 877-326-1999

When you make an appointment, the TeamstersCare Dental Offices set aside time exclusively for you. You will be required to **pay $10** if you do not:

- show up for your appointment, or
- call at least 24 hours ahead of time to cancel

Option #2: Dental Blue Freedom Network Dentists

TeamstersCare has contracted with Blue Cross Blue Shield of Massachusetts (BCBSMA) for coverage through a group of private dentists who provide both routine and specialty services and, at the same time, help you save money on dental care.

TeamstersCare participates in Dental Blue Freedom which gives you access to Dental Blue PPO, Dental Blue, and Dentemax which is a national network. You have great flexibility in your choice of dentists; however, you will receive the largest discount if you choose a Dental Blue PPO dentist. The larger network, Dental Blue, offers access to over 90% of all practicing dentists in MA, however your share of the costs will generally be higher than with a PPO dentist. If you're away from home, you also have access to the Dentemax national network of BCBS dental providers.

Your Dental Blue Freedom ID Card

You will receive a Dental Blue Freedom ID card that you must show whenever you visit a private dentist—whether or not that dentist is in one of the Dental Blue Freedom networks.

- For a Dental Blue Freedom dentist—the card ensures that you will receive the TeamstersCare discount
- For any other private, non-network dentist—the card provides information the dentist will need for accurate billing

To determine whether a particular dentist is in one of the Dental Blue Freedom networks, go to **www.bluecrossma.com** or call BCBSMA's Customer Service at 1-800-241-0803. Have your Dental Blue Freedom ID card available so you can refer to it for TeamstersCare group information.

Option #3: Non-Network Dentists

You do not have to go to a dentist in one of the Dental Blue Freedom networks. You have the flexibility to go to any dentist you wish. However, when you go outside one of the Dental Blue Freedom networks, you'll generally have to pay an even larger share of the cost, and you may be involved in some paperwork.

Costs for Dental Blue Freedom Network and Non-Network Dental Services

Dental Blue Freedom Benefits Fee Schedule

TeamstersCare has a pre-set Dental Fee Schedule of the dollar amounts it will pay for covered dental procedures when those procedures are performed by any dentist other than our own in-house practitioners in Charlestown, Chelmsford, and Stoughton.

The TeamstersCare Dental Fee Schedule is subject to change. To view the current fee schedule, go to www.teamsterscare.com or contact Charlestown Member Services.

Your Share

For any given procedure, the Plan always pays the same amount, regardless of whether you go to a Dental Blue Freedom network dentist or a non-network dentist. In either case, you pay a portion of the bill. The difference is, most likely the Dental Blue Freedom dentist will charge you less to begin with, because of our TeamstersCare contract with BCBSMA. Thus, the balance you pay to a Dental Blue Freedom network dentist—after TeamstersCare makes its pre-set contribution—will almost certainly be smaller than the portion you'd have to pay to a non-network dentist.

Deductibles and Calendar Year Maximum

Except for diagnostic and preventive services, any dental treatment you receive outside of the TeamstersCare Dental Offices is subject to a $50 per person/$100 per family calendar year deductible. Also, there is a calendar year maximum benefit of $2,500 per person.

Orthodontics

Orthodontic Services are covered at 50% of cost, up to a $2,000 lifetime maximum per person. Coverage is available for the member, spouse, and eligible dependents.

Total Health Solutions

Your dental coverage through Dental Blue Freedom includes enhanced benefits through Total Health Solutions. This is a program which identifies patients with certain health conditions that are impacted by dental care and provides them with additional benefits. These conditions include coronary artery disease, diabetes, oral cancer and pregnancy.

Dental Treatment in the Hospital

If you have a serious medical condition and therefore can't be treated in a dental office, your dentist might recommend that you be treated in a hospital. Generally, the TeamstersCare dental benefit will share the cost of the dental services you receive in the hospital—but not any related medical costs. For medical coverage and claims, you'll need to follow whatever procedures are appropriate for the medical insurance plan in which you and your family are enrolled.

Dental Expenses Not Covered

TeamstersCare does not provide dental benefits for the following:

- services or supplies in a hospital operated by the U.S. government or a government agency
- services under any government law or program to which you might be entitled
- treatment of a work-related condition
- cosmetic dental services—unless the procedure is required because of an accident that happens while you are covered by TeamstersCare, subject to the rules of the Plan
- treatment by anyone other than a licensed dentist or physician—or a qualified dental technician working under a dentist's or physician's direction
- training or supplies used for dental care education
- treatment for temporomandibular joint (TMJ) syndrome—except for specific medical conditions verified by x-ray or other diagnostic tests
- experimental procedures
- charges exceeding amounts listed in the TeamstersCare Dental Benefits Fee Schedule
- charges you or your family members are not obligated to pay
- services provided for injuries that result from a war, declared or undeclared
- charges for missed appointments

Pre-Treatment Dental Estimates

BCBSMA can help you estimate your share of dental expenses before you're actually treated.

If your dentist recommends extensive treatment, the dentist can submit a Pre-treatment Estimate Form to BCBSMA for an estimate of your share of the cost. Getting the estimate is voluntary, but it can help avoid surprises about the amount you're responsible for. You can then plan the treatment and manage your expenses accordingly.

Filing a Dental Claim

When you use a TeamstersCare in-house dental facility, you file no claim forms.

BCBSMA handles any claim submitted by Dental Blue Freedom network dentists as well as any non-network claims.

If you have to submit a dental claim yourself, the appropriate forms should be available at your dentist's office. Otherwise, call BCBSMA Member Service directly, at 1-800-241-0803 to obtain a form.

Important Note:* *You must submit dental claims within 12 months of the date when the service was provided.

Dental claim forms for in-network and non-network services should be addressed to:
Blue Cross Blue Shield of MA
P.O. Box 986030
Boston, MA 02298

If you have any questions about how a claim should be handled, call BCBSMA at 1-800-241-0803.

Coordinating with Other Dental Plans

If you or a dependent has other dental coverage—such as through your spouse's plan—any benefits you receive from that other plan will be coordinated with your TeamstersCare benefit. Taken together, total payments from all plans cannot be more than 100% of the charges (see page 57 for details on Coordination of Benefits).

Vision Benefit

TeamstersCare has contracted with Davis Vision to provide you and your family with benefits that help protect your eyesight—while also managing the cost of caring for your vision needs.

Davis Vision Network

Davis Vision is a national network with participating providers throughout the United States. Under TeamstersCare's Plan, you can visit any Davis Vision provider for a broad range of eye care services and supplies—generally, at no cost to you.

For a list of participating providers, call Davis Vision at 1 (800) 999-5431, visit **www.davisvision.com**, or contact Charlestown Member Services for a list of New England providers. (see page 76 for contact information).

Your TeamstersCare Vision Benefit

Participating Davis Vision professionals can provide you and your family members with the following:

- routine eye examinations, at no cost to you
  - for you and your spouse—one exam each, every 24 months
  - for eligible children—one exam, every 12 months

and

- either eyeglasses from the Plan's eyewear selection, at no cost to you

or

- contact lenses, for a $25 copayment

Important Note:* *When choosing either eyeglasses or contacts, you must make your full selection at the time that you have your authorized eye examination. If you go to a provider who only provides an exam, you must order your glasses or contacts through another provider within 30 days in order for the glasses or contacts to be covered.

Eyewear You Can Select

The Plan offers a wide assortment of eyeglasses, all with a one-year warranty. You can select:

- at no cost to you — eyeglasses; a wide variety of frames and lenses; prescription sunglasses; safety glasses (for members only)

or

- for a $25 copay
  - standard, daily-wear soft contact lenses

  or

  - a three-month supply of disposable lenses with a cleaning kit

  and

  - all visits needed to fit the lenses and provide follow-up care

The TeamstersCare eyewear options differ for you and your dependents:

- As a **Plan member**, you can receive as many as **three pairs of eyeglasses** during any consecutive 24-month period. You must select all three pairs at the time of your examination. The following options apply to the combinations you can select:
  - One of your three pairs can be non-prescription (plano).
  - One of your three pairs can be safety glasses.
  - One of your three pairs can be sunglasses.
  - Prescription lenses—two of your three pairs can have any combination of special lenses (e.g., invisible bifocals; trifocals; photo-gray tinting; premium anti-reflective coating; transitional, progressive, or intermediate vision lenses). However, if you select prescription lenses for all three pairs, then at least one pair must be single vision lenses.
- Your **eligible spouse** can receive **two pairs of eyeglasses**, during any consecutive 24-month period, in any combination of lenses. Both pairs must be prescription and both must be selected at the time of the eye examination.
- Your **dependent children** can receive **one pair of prescription eyeglasses** every 12 months. The eyeglasses must be selected at the time of the eye examination.

If You Choose Contact Lenses

You can select either contact lenses or eyeglasses, but not both. If you choose contact lenses, you then have to wait 24 months (12 months for an eligible dependent child) before you can select eyeglasses from the Plan. Also, once the contact lenses are fitted, you cannot exchange them for eyeglasses.

The Plan does not cover extra contact lenses, replacements, or contact lens insurance. However, if you select disposable lenses, you may purchase additional lenses for a discount from Davis Vision. For information on this option, call 1-800-LENS123.

If you select contact lenses, you have to pay a $25 copay directly to the Davis Vision provider. If you need a type of contact lens not available from the Plan, TeamstersCare will pay for your eye exam, but you must pay all other costs.

Laser Vision Correction

TeamstersCare has negotiated a 25% discount from the usual and customary fee if you choose to have laser vision correction surgery at a participating Davis Vision facility.

Important Note:* *TeamstersCare and the TeamstersCare medical options through BCBS do not cover the cost of laser vision surgery.

Making an Appointment

To schedule an appointment, contact a local Davis Vision provider's office directly. To locate a Davis Vision provider, you may call **1 (800) 999-5439** or visit **www.davisvision.com**.

When you call, the Davis Vision provider will help determine whether you're eligible for an examination and eyeglasses under the Plan. In addition, you can check on your eligibility for services by calling **1 (800) 999-5439** or by logging into your account at **www.davisvision.com**.

You should have received a List of Participating Davis Vision Providers in your enrollment kit. However, if you need another copy or more information about your benefits through Davis Vision, call Charlestown Member Services (see page 76 for contact information).

Important Note: ***For routine vision care, it's important to remember that equipment, services, and supplies are covered only through the TeamstersCare vision benefit at a Davis Vision network provider, not through your medical plan.***

TeamstersCare Employee Assistance Program (EAP)

TeamstersCare offers members and their eligible dependents an Employee Assistance Program (EAP) benefit. This program offers advice and guidance for any behavioral health issue or substance abuse concerns. It's a confidential service, provided at no cost to you, available by phone or in person. Call our Clinical Professionals at **1 (800) 851-8326** for:

- Short-term counseling sessions (up to 3 visits)
- Assessment and referrals
- Case Management
- Addiction Issues
- Advice or Guidance with:
  - Personal problems
  - Family and Relationships
  - Financial and Legal concerns
  - Panic, anxiety & stress
  - Child emotional or autism issues
  - Grief counseling
  - Concerns about aging parents
  - Job loss or job stress

Not sure where to begin? Don't hesitate to call the TeamstersCare EAP at **1 (800) 851-8326**. Our staff is committed to helping you and your family members get back on track.

R.A.F.T.

TeamstersCare sponsors a program called R.A.F.T. ("Referral and Follow-Up Team") … a group of volunteers helping their fellow members fight against alcohol and drug abuse. R.A.F.T. meets regularly at designated TeamstersCare sites. For more information—on a strictly confidential basis—call R.A.F.T.'s Program Director at TeamstersCare in Charlestown at **1 (800) 851-8326**.

Hearing Care Benefits

Once each year, you, your spouse, and your children (ages 3 and above) can have comprehensive hearing testing done at the Charlestown Audiology Office. Routine hearing examinations, diagnostic evaluations, and middle ear analysis are provided at no cost to you. Ordinarily, hearing care services and equipment are covered only when they are provided at our TeamstersCare Audiology Office in Charlestown.

This benefit is available to you whether you're enrolled in the TeamstersCare HMO or the Out of Area Option.

Our TeamstersCare staff audiologist can provide the following services:

- ear examination
- diagnostic hearing evaluation
- middle ear analysis
- hearing aid analysis, fitting, and follow-up, as appropriate

To schedule an appointment for a hearing exam for yourself, or your eligible dependents ages 3 and up, call our TeamstersCare Charlestown appointment desk at **(617) 241-9220 option 1**.

Hearing Care Benefits Outside of New England

Ordinarily, hearing care equipment, services, and supplies are covered only when they're provided through our TeamstersCare Charlestown Audiology Office. However, if you or your family members live outside New England, you may be authorized to receive certain hearing care services from a private audiologist, provided our TeamstersCare audiologist conducts a pre-treatment review.

TeamstersCare will use the results of the review to identify and pre-approve reimbursable costs for services and devices from the outside provider. As appropriate, certain reasonable and customary allowances may apply. For more information on this option, call the Audiology Office in Charlestown at **(617) 241-9220 option 1** or **(800) 225-6135** (toll free out-of-state).

Other Benefits

Weekly Disability Benefit

Your TeamstersCare Weekly Disability Benefit is designed to pay you a weekly benefit while you're disabled. The disability must be caused by an illness or injury that is not related to your job. All disability claims are subject to review by the TeamstersCare Disability Panel.

The Weekly Disability Benefit also includes maternity as an eligible disability for however long it's medically necessary for you to be out of work. Generally, "medically necessary" means your physician determines that your pregnancy, or a condition arising out of your pregnancy, prevents you from performing your job.

Your Disability Coverage

If you have a disability not caused by your job that prevents you from working, the TeamstersCare Weekly Disability Benefit pays you a benefit each week, for up to 26 weeks, after a seven-day waiting period. In order to be eligible, you must submit the appropriate form (available from Charlestown Member Services) completely filled out by you and your medical provider. You must also provide a copy of a recent paycheck stub showing your hourly wage.

In order to receive Weekly Disability Benefits, you have to be under the care of a medical doctor, osteopathic physician, physician's assistant, nurse practitioner or licensed mental health provider. During your disability, TeamstersCare may require your provider to fill out an Extension of Benefits Form, which will then be reviewed by the TeamstersCare Disability Panel.

If approved by the TeamstersCare Disability Panel, your weekly disability benefit equals 75% of your regular weekly base pay, from a minimum of $300 per week up to a maximum of $600 per week. In no event can this benefit be greater than 100% of your average weekly pay. TeamstersCare uses your most recent eligibility determination period and a paycheck stub from your employer (provided by you) to calculate your disability rate. Your average hours per week will be calculated based on the average hours for the three highest months reported in the 6-month eligibility determination period that gained you coverage. Your average weekly wages will be calculated based on the straight time rate of pay listed on the paycheck stub that you provide. This paycheck stub must be dated within the most recent eligibility determination period.

The Government considers disability benefits—to which you do not contribute—taxable income. TeamstersCare deducts the appropriate FICA tax from your check and mails you a W-2 form at the end of the year. You may elect to have income taxes deducted from your weekly disability check by submitting a written request to TeamstersCare, detailing the additional amounts to be withheld.

Important Notes:

- ***Your TeamstersCare disability benefit will be reduced by any disability-related payments you might receive from Workers' Compensation, government disability, an auto insurance carrier or any other group plans.***
- ***The maximum weekly disability benefit you may collect is 26 weeks from the date of injury.***
- ***Any payments you receive from Workers' Compensation or an automobile insurance carrier count toward this 26-week maximum.***

- ***You must be in good standing with your employer(s) (i.e., if not for your disability, you would be scheduled for available work) in order to be approved for weekly disability benefits.***
- ***The Fund makes disability payments only so long as a member is working for a contributing employer and remains eligible according to the eligibility and participation provisions of the TeamstersCare Plan. Like other TeamstersCare benefits, weekly disability payments are discontinued when, for whatever reason, a member loses eligibility.***

Disability Waiting Period

After a seven-calendar-day "waiting period," your benefit payments start on the eighth day you're disabled and may be extended for up to 26 weeks with appropriate documentation of proof of disability.

The seven-day waiting period begins on one of two days, depending on when you visit your doctor and have your disability verified:

- If you visit the doctor and receive verification anytime within the first three days of the day you became disabled, the seven-day waiting period begins on the first day you were disabled.
- If you do not see your doctor and receive verification within three days after you're disabled, then your seven-day waiting period starts three days before your first doctor's visit.
- In certain situations, such as a member who is disabled intermittently due to scheduled recurring chemotherapy or radiation treatment for cancer, the seven day waiting period need not be seven consecutive days. In these unusual situations, the TeamstersCare Disability Panel will examine submitted medical documentation to determine if the episodes of disability are part of the same medical disability and meet the necessary criteria. If the Committee approves, the waiting period may be counted as seven calendar days that are not consecutive.

More Than One Period of Disability

TeamstersCare pays benefits on a per-disability basis. This means you can receive up to 26 weeks of benefits each time you're disabled. In order for two periods of disability to be treated as separate, you must have actively, physically returned to work for at least 80 hours between the end of the first period of disability and the beginning of the second period of disability. So, for example, you could not use vacation time or sick time to "bridge the gap" between the two disability periods.

If you go back to work, but work fewer than 80 hours after a disability ends, and you become disabled again for the same or a related condition, then your second period of disability will be considered an extension of the first. However, you would not have to meet another seven-day waiting period, and you could continue to receive benefits for up to the remainder of the original 26-week period.

In certain unusual situations, such as a member who is disabled intermittently due to scheduled recurring chemotherapy or radiation treatment for cancer, the seven day waiting period need not be seven consecutive days. In these unusual situations, the TeamstersCare Disability Panel will examine submitted medical documentation to determine if the episodes of disability are part of the same medical disability and meet the necessary criteria. If the Disability Panel approves, the waiting period may be counted as seven calendar days that are not consecutive and the requirement of returning to work for more than 80 hours necessitates an additional seven-calendar-day waiting period will be waived.

Continuing TeamstersCare Medical Coverage While Disabled

If you're disabled and are receiving either TeamstersCare Weekly Disability benefits (for a non-work-related disability) or Workers' Compensation (for a work-related disability), you may be able to continue

receiving TeamstersCare medical benefits during the period of your disability. In either case, you must meet all of the Plan's eligibility rules.

Non-Work-Related Disability

If you're disabled from a non-work-related injury and are receiving TeamstersCare Weekly Disability benefits, you may be eligible to continue your TeamstersCare medical benefits.

TeamstersCare will credit you with hours toward continuing eligibility at a rate of 22 hours per week, for up to 26 weeks.

You cannot be credited with a total of more than 572 "disability" hours in any consecutive three-year period.

Work-Related Disability

If you're disabled from a work-related injury and are receiving Workers' Compensation, you may be able to maintain your TeamstersCare medical coverage so long as you meet all of the Plan's eligibility requirements and your employer continues to contribute to TeamstersCare at a rate of 32 hours per week. Contributions are made in accordance with the Collective Bargaining Agreement between the Union and your employer. In most cases contributions will continue for up to 12 months.

Disputed Work-Related Disability

If you've filed a Workers' Compensation claim which is disputed by your employer or the Workers' Compensation carrier, then—during the period when the claim is being adjudicated—TeamstersCare may pay you a weekly disability benefit provided:

- you sign a notarized Assignment and Consent to Lien Agreement committing to repay any amounts you have received from the Plan should you (1) become eligible for Workers' Compensation benefits or (2) receive proceeds from a Workers' Compensation claim
- you provide TeamstersCare with a copy of the Workers' Compensation denial
- you retain an attorney and dispute the denial
- you complete a TeamstersCare Third-Party Questionnaire Form

Important Note:* *During the period when you are disabled from a work-related injury or illness and receiving Workers' Compensation, TeamstersCare does not cover any medical or pharmacy expenses that are attributable to the injury or illness. In addition, the maximum weekly disability benefit that you may collect is 26 weeks from the date of injury. Any payments that you receive from Workers' Compensation count toward this 26-week maximum.

Continuing Life Insurance While Disabled

If you become totally and permanently disabled while you're covered by TeamstersCare life insurance, but then lose your eligibility for benefits, your life insurance may remain in effect for a certain period of time, provided you continue to be totally disabled. In this case, you must complete and return an application for review within the required timeframe and the life insurance carrier determines your eligibility. If approved, there will be no cost to you as TeamstersCare will pay the premiums on your behalf. The length of time this extended coverage remains in effect depends on how old you are when disability begins (see page 40 for details on Life Insurance Benefits If You're Disabled).

Important Note: ***"Totally and permanently disabled" means that your disability prevents you from working at any kind of paying job you would normally be qualified to perform***.

Disability TeamstersCare Does Not Cover

TeamstersCare does not provide benefits for job-related medical expenses or job-related disabilities which are eligible for coverage by Workers' Compensation, state disability laws, no-fault insurance or other group plans.

Disability Resulting from Motor Vehicle and Motorcycle Accidents

If you have a disability claim related to a motor vehicle or motorcycle accident, you, or someone acting on your behalf, must notify TeamstersCare as soon as possible. The Plan's coverage varies with a number of factors.

States Requiring Mandatory No-Fault Insurance

If you live in Massachusetts, or any other state with no-fault insurance, disability claims resulting from a motor vehicle accident are covered by mandatory no-fault insurance. If you are covered by such insurance and you are in a motor vehicle accident, then TeamstersCare will not pay weekly disability for any week in which you also receive insurance payments. However, if you reach the no-fault maximum before the 26th week that you're disabled, TeamstersCare may pay benefits for up to the rest of the 26-week period.

If you have elected not to carry no-fault coverage, and you have a disability claim resulting from a motor vehicle or motorcycle accident, TeamstersCare excludes from your benefits all amounts that would have been covered had you obtained no-fault insurance.

States Without No-Fault Insurance

If you live in a state that does not require mandatory no-fault coverage, the Plan will administer motor vehicle or motorcycle accident claims in the same way as any other disability claim. However, you'll first have to sign an Assignment and Consent to Lien Agreement which requires that if you receive any third-party settlements related to the accident, you must reimburse TeamstersCare an amount equal to any payment the Plan may have made on your behalf.

For coverage of medical claims resulting from motor vehicle accidents, see Third Party Liability on page 59.

Important Note: ***If you are denied benefits under your motor vehicle insurance due to driving under the influence, TeamstersCare excludes from your benefits all amounts that would have been covered by the insurance carrier.***

Other Disability Settlements

In general, if you receive a settlement to compensate you for a disability, you must reimburse TeamstersCare for any medical and disability benefits the Plan may have paid you for that same disability.

This also applies to a retroactive determination from the Social Security Administration. If you receive compensation from another carrier or agency, you must contact TeamstersCare immediately to arrange for repayment.

If you're disabled and are receiving disability payments from a third party, your hours continue to accrue towards your continuing eligibility for TeamstersCare medical coverage—just as they would if TeamstersCare were making your disability payments.

Filing a Weekly Disability Claim

If you need a Weekly Disability Claim Form, call Charlestown Member Services. Fill out your portion of the Form, and then have your medical provider complete their section. You must return the completed Form to TeamstersCare within 90 days of the date your disability begins. If you do not return the Form within 90 days of the date your disability begins, you will not be eligible for disability benefits.

The TeamstersCare Disability Panel will review the information you provide and will contact you if more information is needed.

Important Note: ***Disability payments cannot begin until you've submitted a properly documented claim that has been approved by the TeamstersCare Disability Panel.***

Information You Must Provide to be Eligible for Weekly Disability Benefits

TeamstersCare cannot pay weekly disability benefits without obtaining all the information it needs to process your claim.

- When you first have a claim, you must, within 90 days of the date your disability begins: (1) submit the appropriate Disability Claim Form, (2) sign a Release of Information Form, and (3) provide TeamstersCare with a paycheck stub detailing wages for a pay period within the most recent eligibility determination period.
- In order to begin or continue your weekly disability benefit, TeamstersCare may need to review certain documents related to your disability. This could include such items as doctor's office notes and supporting data such as x-rays, MRI's, etc.
- For prolonged periods of disability, TeamstersCare may require your physician to periodically complete and return an Extension of Benefits Form, which will then be reviewed by the TeamstersCare Disability Panel.
- When your disability is over and you return to work, you must notify TeamstersCare immediately. Teamsters Union 25 Health Services & Insurance Plan will take all necessary steps to recover any benefits it paid out because of late or improper notification.
- If you would like federal and/or state income taxes withheld from your disability check, notify Charlestown Member Services.

Important Note: ***If you work while out on disability and you have not been cleared to return to work by the doctor who treated your disability, your TeamstersCare weekly disability benefits end.***

Life Insurance

The TeamstersCare life insurance benefit provides financial protection for your family or beneficiaries in case of your death. TeamstersCare contracts with an insurance carrier to provide this benefit.

Life Insurance Benefit Amount

If you die from any cause, on or off the job, TeamstersCare pays your beneficiaries a benefit of $50,000.

Naming Your Beneficiary

You can designate anyone you choose as your beneficiary—or you can name several people as multiple beneficiaries.

You must name your beneficiaries at the time you complete your TeamstersCare Enrollment Form, but you can change your designation at any time, provided you do so on a Form provided by the Plan. If you name more than one beneficiary you must also specify how you wish your life insurance benefit to be divided.

If you do not name a beneficiary, or if your primary beneficiary dies before you and there is no contingent beneficiary designation on file, your life insurance benefit will be paid according to the life insurance carrier's guidelines. Please contact Member Services if you wish to receive a copy of the insurance policy documents.

Living Benefits/Accelerated Death Benefit Option

TeamstersCare offers a special life insurance option which is for members only that applies if you are diagnosed by a doctor as having a terminal condition.

The maximum amount available is 75% of your total $50,000 life insurance benefit. There are no restrictions on how you use the money you receive. The amount of life insurance payable for you in the event of death will be reduced by the amount of living benefits already paid to you.

To apply for living benefits, contact Charlestown Member Services at 617-241-9220, ext. 2.

Dependent Life Insurance

TeamstersCare provides you with a benefit that can help cover the unexpected expenses resulting from the death of an eligible spouse or dependent child.

TeamstersCare pays dependent life benefits directly to the member, as a lump sum, for these amounts:

- $5,000—death of your spouse
- $2,000—death of an eligible dependent child

Under the TeamstersCare Dependent Life Insurance Benefit, dependent coverage includes life insurance only, not the accidental death & dismemberment benefit. The Plan does not pay benefits for the death of an ex-spouse.

Converting TeamstersCare Life Insurance to an Individual Policy

If your TeamstersCare life insurance ends for any reason, you can "convert" from TeamstersCare coverage to an individual policy. You will need to pay the premiums for this continued coverage.

To convert, you will not need to show proof of good health. However, you must apply for the conversion and pay the first premium within 31 days after your active TeamstersCare coverage ends.

In addition, if you should die anytime during the 31-day conversion period, TeamstersCare will pay to your designated beneficiary the full amount of insurance you would have been entitled to convert.

Life Insurance Benefits if You're Disabled

If you become totally and permanently disabled while you're covered by TeamstersCare life insurance, you may be able to continue life insurance at no cost to you, subject to certain conditions and provided you continue to be totally disabled. Coverage is for you, the member, only.

The length of time coverage remains in effect depends on how old you are when disability begins, as shown in the following schedule:

Age When You're Disabled	How Long Your Life Insurance Coverage Continues
Less than 60	up to age 65
60 to 64	5 years
65 to 69	up to age 70, but not less than 1 year
70 and over	1 year

To be eligible for extended life insurance coverage, you have to be "totally and permanently" disabled. This means your disability prevents you from working at any kind of paying job that you would normally be able to perform.

If you're "totally and permanently" disabled, you have to submit evidence of your disability to the life insurance carrier within 15 months of your first date of disability. From that time on, at reasonable intervals, you may be required to submit medical proof that you continue to be totally disabled, or the life insurance carrier may require an examination by a physician of their choice, at no cost to you.

If you lose eligibility while you're disabled, you may wish to convert to individual coverage (see page 39 for details on Converting Life Insurance to an Individual Policy) until you're notified that your extended coverage has been approved. Once your extended coverage has been approved, any premium you've paid for the converted policy will be returned to you.

If you become totally disabled, contact Charlestown Member Services immediately to discuss these options (see page 76 for contact information).

Filing a Life Insurance Claim

To file a life insurance claim:

- a family member must call TeamstersCare and ask for the appropriate claim form
- TeamstersCare will send the claim form to the designated beneficiary
- the beneficiary completes and returns the form to TeamstersCare within 12 months of the date of death
- a certified copy of the death certificate must be provided

See page 69 for details of the Plan's Claims and Appeals procedures.

Accidental Death & Dismemberment Insurance

The TeamstersCare Accidental Death & Dismemberment (AD&D) Insurance Benefit provides the member with additional life and accident insurance protection. AD&D coverage is provided for the member only. TeamstersCare contracts with an insurance carrier to provide the AD&D benefit.

If the member suffers certain kinds of serious injury as the result of an accident, TeamstersCare pays the AD&D benefit directly to the member.

If the member dies as the result of an accident, the AD&D insurance pays a benefit to the beneficiary designated by the member. The Plan makes this AD&D payment in addition to the normal life insurance benefit.

AD&D Basic Benefits

If the member dies within 365 days of an accident, or has one of the injuries described in this chart, TeamstersCare pays the following benefits: (Note: Principal Sum is equal to $50,000)

Loss	**Benefit**
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-fourths Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum
Third degree burns covering 75% or more of the body surface	Principal Sum
Third degree burns covering 50 to 74% of the body surface	Three-fourths Principal Sum

The Plan's insurance policy has certain technical definitions of the particular losses, limbs, or faculties identified in this chart. If you need specific information on any of the occurrences described above, contact Charlestown Member Services (see page 76 for contact information).

Important Note: ***The maximum AD&D benefit from any one accident is $50,000.***

Airbag Benefit

TeamstersCare will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if a member was Injured in an Accident while driving or riding in the front seat of an Automobile directly behind an Airbag.

A benefit will not be paid if the Accident occurs when the:

- Automobile was being used for racing, stunting, or exhibition work;
- Airbag was disengaged; or
- Insured Person was breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Seat Belt Benefit

TeamstersCare will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if:

- a member was Injured in an Accident while driving or riding in an Automobile and wearing a Seat Belt;
- the member's death resulted from such Injury; and
- a copy of the police department's accident report is submitted with the claim.

A benefit will not be paid if the Accident occurs when the:

- Automobile was being used for racing, stunting, or exhibition work;
- Seat Belt was used to restrain more than one person;
- Automobile is equipped with an automatic Seat Belt and the lap belt is not fastened; or
- The member was breaking any laws of the jurisdiction in which the Accident occurred.

This benefit is payable in addition to any other applicable benefits under the Policy.

Childcare Benefit

TeamstersCare will pay a monthly benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. The benefit is payable for each Dependent child under the age of 12, and may be paid to You, Your Spouse or the Dependent child's legally appointed guardian, as applicable.
The benefit amount will be paid at the end of the month for up to 2 years if:

- You are Injured in an Accident and that Injury results in death;
- You, Your Spouse or the Dependent child's legally appointed guardian incurs expenses for Childcare services within 365 days of Your death as a result of employment, education or training; and
- TeamstersCare receives satisfactory proof of the Childcare expense incurred by You, Your Spouse or the Dependent child's legally appointed guardian.

If both parents of a Dependent child are insured under the Policy, benefits under this provision will be limited to payment under only one parent.

Child Education Benefit

TeamstersCare will pay a benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. This benefit will be paid at the end of each school term for each Student for up to 4 consecutive years. This benefit may be paid to the Student or, if a minor child, to the Student's legally appointed guardian, if:

- You are Injured in an Accident and that Injury results in death;

- a Dependent child is or becomes a Student within one year after Your death;
- the Student continues to be enrolled for each consecutive term; and
- a copy of the Student's most recent grade report and tuition statement is submitted with the claim.

If both parents of a Student are insured under the Policy, benefits under this provision will be limited to payment under only one parent. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Important Note: ***For purposes of this benefit, the term Student does not include a Dependent child attending high school.***

Coma Benefit

TeamstersCare will pay a monthly benefit amount of 5% of the Principal Sum. Benefits will be payable to the member's legal representative or legally appointed guardian at the end of the month for up to 20 months if:

- the member was Injured in an Accident and, as a result, becomes Comatose within 31 consecutive days of the Injury; and
- the member remains Comatose for 31 consecutive days.

If the member's Glasgow Coma Score temporarily becomes nine (9) points or higher and then reverts to eight (8) points or less, this will not cause a discontinuance in the benefit payment if the lapses and subsequent Coma recurrences are due to the same Injury.

Felonious Assault Benefit

TeamstersCare will pay a benefit amount of 20% of the Principal Sum, up to a maximum of $25,000 if:

- a member is Injured as a result of a Felonious Assault and that Injury results in a loss shown in the Table;
- a copy of the police report is submitted with the claim; and
- the Felonious Assault was not committed by a Family member.

Certain exclusions apply. This benefit amount is payable in addition to any other applicable benefits under the policy.

Naming Your Beneficiary

Unless you designate otherwise, the beneficiaries for your AD&D benefit will be the same person or persons you designate as beneficiaries for your life insurance (see page 39 for details on Naming Your Beneficiary).

Exclusions

An Accidental Death or Personal Loss benefit will not be paid for any loss which:

- results, whether the member is sane or insane, from an intentionally inflicted injury or sickness or suicide or attempted suicide;
- results from the member's participation in a riot or in the commission of a felony;

- results from an act of declared or undeclared war or armed aggression, if the cause of the death occurs while the insured is serving in the military or within six months after termination of service in the military forces;
- is incurred while the member is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agency are liable;
- which is not permanent, unless specifically provided;
- occurs more than 365 days after the injury; except that this 365 day limit will not apply if the member is Comatose or being kept alive by an artificial support system at the end of the 365 days;
- does not result from an Accident;
- is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
- results from injuries the member receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly scheduled flight or while the member is traveling on business of the employer;
- results from injury received while riding in any aircraft engaged in racing, endurance tests or acrobatic or stunt flying;
- is caused by the member and is a result of injuries received while under the influence of any controlled drug unless administered on the advice of a physician;
- is caused by the member and is a result of injuries the member receives while voluntarily intoxicated.

How to File an AD&D Claim

To file an AD&D claim, you or a family member must:

- call Charlestown Member Services and request an AD&D claim form (see page 76 for contact information)
- complete and return the form to TeamstersCare within 12 months of the date of injury or death, and
- provide a certified copy of the death certificate and other documents as requested.

Modern Assistance Programs, Inc. (MAP)

Qualified members and their eligible dependents have a second option when seeking support for behavioral health issues through the Modern Assistance Programs, Inc (MAP). They can be reached at (617) 774-0331.

MAP offers a wide range of services to address mental health and substance abuse concerns, including:

- Short-term counseling
- Education and training
- Assessment and referrals
- Case management
- Drug testing referral and monitoring
- Problem resolution
- Client advocacy
- Advice or Guidance with:
    - Addiction treatment
    - HIV/AIDS
    - Family therapy
    - Panic, anxiety & stress
    - Domestic & workplace violence/trauma
    - Mental health
    - Rehabilitation counseling
    - Alternative health care referrals

There is on-call availability 24 hours a day, seven days a week. Counseling is available by telephone or in person (see contact information on page 77).

Administration

Continuing Your Health Coverage under COBRA

If you lose eligibility for TeamstersCare medical benefits for reasons called "qualifying events," you can continue your health coverage under a Federal law called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Under COBRA, you can maintain your current TeamstersCare health coverage (i.e., under the TeamstersCare HMO or the Out of Area Option). You will have to pay the full cost of your health benefits, plus a 2% administration fee, through monthly premiums.

COBRA affects only your healthcare benefits. The law does not provide for continuation of other coverage such as life, disability, or AD&D insurance. However, while you are covered by COBRA, you may also elect to continue dental and vision care benefits by paying a higher monthly premium.

When you become eligible for COBRA, you can extend coverage for yourself, your spouse, and your dependents who were covered at the time of the qualifying event. In addition, during the period when you are covered by COBRA, the following persons are also automatically eligible:

- any newborn or adopted child added to your family
- any child placed with you (the member) for adoption
- a spouse who becomes your dependent if you marry

To enroll these new dependents, you must notify Charlestown Member Services within 31 days of the birth, adoption, or marriage. Your newborn or adopted child(ren) or child(ren) placed with you for adoption during your period of COBRA continuation coverage are considered qualified beneficiaries and have independent rights to elect and change elections under COBRA. However, your new spouse or other dependents added during your COBRA continuation coverage period are not qualified beneficiaries and do not have independent COBRA rights.

Important Note:* *COBRA continuation of coverage is authorized by Federal law. If the law changes, then eligibility for continued coverage might also change.

Types of Coverage

When you elect COBRA, you can choose one of two levels of coverage:

- **Option #1:** Medical and behavioral health benefits, prescription drug coverage, EAP benefits and hearing care

or

- **Option #2:** Medical and behavioral health benefits, prescription drug coverage, EAP benefits, and hearing care, plus dental and vision care benefits

Important Note:* *Once you have elected one of these two options, you cannot change your selection during your period of COBRA coverage.

The Period for Making Your Decision About COBRA Coverage

To continue coverage under COBRA, you have to submit a TeamstersCare Benefit Continuation Form. You or your eligible dependents must complete and return the Form to TeamstersCare sometime within 60 days of the later of two dates:

- either the date you receive notice of your rights to continue coverage under the Plan, or
- the date your TeamstersCare coverage ends

Cost of Continued Coverage

You and your covered dependents will be required to pay 102% of the full group cost for your continued coverage. However, this cost may be increased to 150% for a qualified 11-month extension of coverage due to disability. See page 11 for details on Continuing Coverage While Disabled, or call Charlestown Member Services (see page 76 for contact information).

Important Note: ***COBRA rates change from time to time, depending on the general cost of healthcare, cost variations among different providers, and the Federal government's decisions about COBRA benefits and administration. If COBRA costs or benefits change in the future, we will let you know ahead of time. For current coverage costs, contact Charlestown Member Services.***

Your first COBRA payment is due no later than 45 days after the date you (or a dependent) elect continued coverage. After you've paid this first premium, you need to continue making payments by the first of every month. However, each month, you have a 30-day grace period in which to pay your premium.

Important Note: ***During a premium-payment "grace period" your eligibility cannot be reactivated nor your claims processed until the premium has been paid. In addition, prescriptions will not be filled at a TeamstersCare Pharmacy or at an Express Scripts/Medco network pharmacy until the payment is processed.***

The first COBRA payment is retroactive to the date of your "qualifying event," the date you lost your active benefits.

Qualifying Events

Continuing Coverage for up to 18 Months

You and your spouse and/or dependents can continue health benefits for up to 18 months if the Fund receives timely notice that you are losing coverage for any one of these "qualifying events":

- you don't work enough hours in an eligibility determination period

  or

- you retire and subsequently lose coverage

  or

- your job ends for any other reason (other than gross misconduct)

Continuing COBRA Coverage While Disabled

Under certain circumstances, you and your dependents may be able to extend medical benefits for a total of 29 months—11 additional months beyond the original 18 months of COBRA continuation coverage. This occurs when you or a covered dependent:

- is disabled under Title II or XVI of the Social Security Act when you stop working for any of the "qualifying events" named above

or

- becomes disabled under Title II or XVI of the Social Security Act anytime during the first 60 days of your initial 18-month COBRA coverage period

Sometime during your first 18 months of continued coverage, you need to obtain a special determination letter from the Social Security Administration (SSA) saying that you or your dependent was disabled under Title II or XVI of the Social Security Act when your qualifying event occurred, or during the first 60 days of your initial 18-month COBRA coverage period.

You must then notify TeamstersCare in writing and provide a copy of the SSA disability determination letter sometime during this same 18-month continuation period and no later than 60 days after you've received your disability determination from Social Security.

Termination of coverage during the 29-month period will occur if you or your dependent is found by the Social Security Administration to be no longer disabled. Termination will occur on the first day of the month beginning more than 30 days after the date of the final determination. All reasons for termination that apply to the initial 18 months will also apply for any additional months of coverage.

Continuing Dependent Coverage for up to 36 Months

In some cases, your dependents can have coverage extended for a total of up to 36 months. Dependents may be eligible for 36 months of continued medical benefits if they would otherwise be losing coverage for any one of the following "qualifying events":

- your death
- your divorce or legal separation
- your entitlement to Medicare
- your dependent no longer meets the Plan's definition of "eligible dependent"

This 36-month continuation period begins at different times, depending on the particular "qualifying event," as follows:

- Your death. Remember that your dependents will continue to receive TeamstersCare health benefits after your death up to the end of the benefits coverage period for which you were last eligible (see page 11 for details on "What happens to coverage when a member dies"). At the end of that coverage period your dependents may then elect to continue their insurance, under COBRA, for an additional 36 months.
- Your divorce or legal separation. The 36-month continuation period begins with the date of divorce or separation.

- Your entitlement to Medicare. The 36-month continuation period begins when you become entitled to Medicare and your dependents would otherwise lose coverage.
- Your dependent no longer meets the plan's definition of "eligible dependent." The 36-month continuation period starts on the date when the dependent no longer qualifies as a dependent under the Plan.

COBRA and Medicare

You are eligible to continue healthcare benefits under COBRA if you become entitled to Medicare and then have a COBRA qualifying event. However, you are not eligible to continue your healthcare benefits if you have a qualifying event and then for the first time become entitled to Medicare after you have elected COBRA continuation coverage. Your dependents can still continue their own medical benefits, provided they have not become covered under some other group health plan. For dependents, this continuation extends for one of two periods, depending on which of the two provides coverage longer:

- either 36 months from the date you first became covered by Medicare,
- or for 18 months following the date of the qualifying event

Example: You are an active Plan member and you turn 65 (and so become covered by Medicare) on March 1, 2017. One year later, as of February 28, 2018, you retire and then subsequently lose Plan eligibility—which is a "qualifying event." You are generally eligible for 18 months of COBRA continuation coverage. Your dependents would be eligible to continue benefit coverage until:

- either 36 months following the date you first became covered by Medicare—which would extend coverage until March 1, 2020
- or 18 months following the date of the qualifying event—which would extend coverage through August 31, 2019

In this example, since the 36-month continuation gives your dependents the longer of the two coverage periods, it's this 36-month period that applies.

More Than One Qualifying Event for Your Dependents

If your dependents become eligible to continue their coverage under more than one "qualifying event," they may be able to extend their health benefits for up to a combined total of 36 months. This total 36-month period begins on the date of the first "qualifying event."

Example: You lose eligibility under one of the "qualifying events" that provides your dependent child with 18 months' continuation coverage—your retirement would be an example.

Sometime during that initial 18-month continuation coverage period, your dependent child no longer meets the plan's definition of "dependent". For example, your dependent turns age 26. This is a second "qualifying event." Your child may then be eligible for additional extended coverage up to a total of 36 months. This 36-month period would begin on the date of the first qualifying event –in this example, your retirement.

Notification of a Qualifying Event

TeamstersCare's responsibility. If you qualify for COBRA and the Fund receives timely notice from your employer that you are losing coverage because you failed to work the required number of hours, then TeamstersCare will take the first action—by notifying you and/or your covered dependents of COBRA eligibility.

Your responsibility. For certain other "qualifying events," you or a family member must take the first step in the process by notifying TeamstersCare of the event. You, your spouse, or a dependent is responsible for this notification if eligibility would otherwise end because:

- you become divorced or legally separated
- your dependent child no longer meets the Plan's definition of "eligible dependent"

For these events, you or your family member must notify TeamstersCare in writing within 60 days of the later of two dates:

- either the date of the "qualifying event"
- or the date TeamstersCare coverage ends

If you do not notify TeamstersCare within 60 days of the event, coverage will terminate.

When COBRA Continued Coverage Ends

If your coverage has been continued for any of the reasons described above, including disability, the extended coverage will end when any one of the following happens:

- You or your dependent fails to pay the cost of continued coverage before the end of a grace period extension (see page 47 for details on Cost of Continued Coverage).
- You become covered under some other employer's group health plan (either as an employee or dependent) after you have already elected COBRA continuation coverage. This does not apply if the other plan limits or pays no benefits for a medical condition you or a dependent already has.
- You first become entitled to Medicare—relative to your own coverage—after you elect COBRA coverage.
- Your spouse or dependent becomes entitled to Medicare—relative to his or her own coverage—after he/she elects COBRA coverage.
- Coverage was continued due to a disability and then Social Security determines you or your dependent is no longer disabled. In this case, termination will occur on the first day of the month beginning more than 30 days after the date of the final determination.

Other Sources of Health Coverage

If you become eligible to elect COBRA continuation coverage, you should consider all options you may have to get other health coverage before you make your decision. There may be more affordable coverage options for you and your family through other group health plan coverage (such as a spouse's plan), the Health Insurance Marketplace or Medicaid.

If you lose eligibility for group health coverage, including eligibility for COBRA, you may have a right to special enroll (enroll without waiting for the next open enrollment period) in other health coverage such as a spouse's plan. You must request special enrollment within 30 days from the loss of your job-based coverage.

Losing your job-based coverage is also a special enrollment event in the Health Insurance Marketplace. The Marketplace offers "one-stop-shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions.

Eligibility for COBRA won't limit your eligibility for Marketplace coverage or for a tax credit. You can apply for Marketplace coverage at **Healthcare.gov** or by calling 1-800-318-2596 (TTY 1-855-889-4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during open enrollment, anyone can enroll in Marketplace coverage.

If You Have Questions about COBRA

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Additional information is also available through EBSA's website at **www.dol.gov/ebsa**

EBSA Headquarters:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-202-219-8776

EBSA Boston Regional Office:

Employee Benefits Security Administration
Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203
617-565-9600 or Toll free: 1-866-444-EBSA (3272)

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) offers protections for millions of America's workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families by:

- Providing additional opportunities to enroll in group health plan coverage when they lose other health coverage, get married or add a new dependent.
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on any health factors.
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under Federal law.

Special Enrollment Rights

Special enrollment allows individuals who previously declined health coverage to enroll for coverage outside of a plan's open enrollment period. There are two types of special enrollment:

- Loss of eligibility for other coverage – Employees and dependents who decline coverage due to other health coverage and then lose eligibility or employer contributions have special enrollment rights. For example, an employee who turns down health benefits for herself and her family because the family already has coverage through her spouse's plan can request special enrollment for her family in her own company's plan.
- Certain life events – Employees, spouses and new dependents are permitted to special enroll because of marriage, birth, adoption or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

Nondiscrimination Prohibitions

Employees and their family members cannot be denied eligibility or benefits based on certain "health factors". They also cannot be charged more than similarly situated individuals based on any health factors. "Health factors" include pre-existing or current medical conditions, claims experience, and genetic information.

HIPAA and the Affordable Care Act (ACA) also provide protections from impermissible discrimination based on a health factor in wellness programs related to group health plan coverage (such as those that encourage employees to workout, stop smoking or meet certain health standards such as a target cholesterol level).

Preserving the States' Role

If a health plan provides benefits through an insurance company or HMO (an insured plan), HIPAA may be complemented by state laws that offer additional protections. For example, states may increase the number of days parents have to enroll newborns, adopted children and children placed for adoption or require additional special enrollment circumstances.

Preexisting Condition Exclusions

The ACA prohibits plans from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014. For prior years, HIPAA limited these exclusions and required plans to offset preexisting condition exclusion periods if the individual had prior health coverage.

For More Information

The Employee Benefits Security Administration (EBSA) offers more information on HIPAA on its website, including Frequently Asked Questions. Contact EBSA electronically at **askebsa.dol.gov** or call toll free 1-866-444-3271.

Privacy & Notice of TeamstersCare Privacy Policies

TeamstersCare is required by law to maintain the privacy of your protected health information (PHI) and to provide you notice of TeamstersCare's legal duties and privacy practices with respect to this health information. PHI includes information which identifies you, **and** relates to your past, present or future physical or mental health condition, the provision of health care to you, or the payment for that care.

If you have questions about any part of this Notice, or if you want more information about our privacy practices, please contact the TeamstersCare Privacy Official at 16 Sever Street, Charlestown, MA 02129, or you may call 617-241-9220.

How TeamstersCare May Use or Disclose Your Protected Health Information

The following categories describe the ways that TeamstersCare may use and disclose your protected health information. We have not listed every use or disclosure that might be included in a given category. However, all the ways we are permitted to use and disclose information fall within one of these categories.

Treatment. Information obtained by a TeamstersCare provider, for example, a dentist or pharmacist, may be disclosed to other healthcare providers who are part of your healthcare team in order to provide you with the best course of treatment.

Payment. We may use or disclose PHI about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, the "payment" category may include determining whether TeamstersCare covers a particular treatment.

Health Care Operations. We may use and disclose PHI about you to carry out necessary insurance-related activities. Such activities could include underwriting, premium rating and other activities relating to plan coverage; conducting or arranging for medical review, legal services, and audit services; and business planning, management, and general administration.

Required by Law. We will disclose your PHI when required to do so by federal, state or local laws. For example, we may disclose your PHI to the U.S. Department of Health and Human Services upon their request if they wish to determine whether we are in compliance with federal privacy laws.

Public Health. As required by law, we may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities. We may disclose your PHI to health agencies, as authorized by law, during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding, such as a lawsuit, in response to a subpoena.

Law Enforcement. As required by law, we may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person; complying with a valid court order or subpoena; and for other law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI to coroners, medical examiners, and funeral directors. For example, this may be needed in order to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. Consistent with applicable law, we may disclose your PHI to organizations involved in procuring, banking, or transplanting organs and tissues.

Public Safety. We may disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security. We may disclose your PHI to authorized federal officials for military intelligence and national security purposes as authorized by law.

Correctional Institutions. We may disclose your PHI to a correctional institution, if you are an inmate, as necessary for your health.

Workers' Compensation. We may disclose your PHI as necessary to comply with Workers' Compensation or similar laws.

Marketing. We may contact you to give you information about health-related benefits and services that might interest you.

Disclosures to Trustees. If you appeal a claim to the TeamstersCare Board of Trustees, we may disclose limited PHI necessary for the purpose of administering plan benefits.

When TeamstersCare May Not Use or Disclose Your Protected Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your protected health information without written authorization from you. Certain types of uses and disclosures of your PHI require an authorization, such as most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. If you do authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose PHI about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Breach Notification

TeamstersCare will notify you if there is a breach of your unsecured PHI. A breach is the impermissible use or disclosure of your PHI.

Statement of Your Health Information Rights

Right to Inspect and Copy. You have the right to inspect and copy PHI about you in TeamstersCare records that may be used to make decisions about your plan benefits. To inspect or copy such information, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. We may deny your request to inspect or copy in certain limited circumstances. In such cases we will provide you with an explanation for the denial.

Right to an Electronic Copy. You have the right to an electronic copy of your PHI in cases where TeamstersCare uses or maintains your PHI in an electronic format. To receive an electronic copy, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. You may direct TeamstersCare to transmit such copy directly to your designee, provided that any such choice is clear, conspicuous, and specific. Any fee for your request will not be greater than TeamstersCare labor costs in responding to your request for the copy.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. TeamstersCare may not be able to comply with all requests. If you would like to make a request for restrictions, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129.

Right to Request Confidential Communications. You have the right to receive your PHI through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. TeamstersCare may not be able to comply with all requests.

Right to Request Amendment. You have the right to request that TeamstersCare amend your PHI when you believe the information is incorrect or incomplete. We are not required to change your PHI and if your request is denied, we will provide you with information about our denial and how you can appeal the denial. To request an amendment, you must make your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. You must also provide a reason for your request.

Right to Accounting of Disclosures. You have the right to receive a list or "accounting of disclosures" of your PHI made by us, except that we do not have to account for disclosures made for purposes of treatment, payment or health care operations, disclosures made to you or others involved in your care, or disclosures that you authorize. To request this accounting of disclosures, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Upon your request, TeamstersCare will provide you with one list per 12-month period free of charge. We may charge you for additional lists.

Right to Paper Copy. You have the right to receive a paper copy of this Notice of TeamstersCare Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. You may also obtain a copy of this Notice at our website, **www.teamsterscare.com**.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the TeamstersCare Privacy Official, at 16 Sever Street, Charlestown, MA 02129 or you may call (617) 241-9220.

Changes to this Notice of Privacy Practices

TeamstersCare reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all protected health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, TeamstersCare is required by law to comply with the current version of this Notice.

For More Information or to Report a Problem

If you have questions about this Notice of Privacy Practices, or about how we handle your PHI, you may contact the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. If you believe your privacy rights have been violated, you can file a complaint with the TeamstersCare Privacy Official. All complaints to TeamstersCare must be submitted in writing and submitted within 60 days of the alleged violation. TeamstersCare will not retaliate against you in any way for filing a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C. 20201. The Secretary may be reached by phone at 1-202-690-7000.

Your Rights Under the Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Protection Act of 1996 (Newborns' Act) puts the decisions affecting length of hospital stays after childbirth in the hands of mothers and attending providers.

The Newborns' Act and its regulations provide that health plans may not restrict a mother's or newborn's benefits, for a hospital length of stay related to childbirth, to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The attending provider may, in consultation with the mother, discharge earlier.

The Newborns' Act prohibits any incentives, either positive or negative, that could encourage less than the minimum protections under the Act.

The Plan may apply its regular deductibles and copayments, provided they do not increase during the mandated minimum hospital stay (for example, by requiring a higher copayment after the first 24 hours of hospitalization).

All TeamstersCare Medical Options are required to adhere to this Act by law.

Your Rights Under the Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 16, 1998, contains protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery related to the mastectomy.

When a plan provides coverage with respect to a mastectomy, coverage is required for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Reconstructive benefits must include coverage for:

- reconstruction of the breast on which the mastectomy has been performed

- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prosthesis and physical complications at all stages of mastectomy, including lymphedemas

These benefits are subject to the plan's usual copayments and/or coinsurance.

The law also prohibits plans from:

- denying a patient's eligibility or continued eligibility in order to avoid the requirements of the WHCRA, or
- establishing incentives, penalties, or inducements for care in a manner inconsistent with the WHCRA.

Coordination of Benefits

If you or a family member has—or acquires—healthcare coverage under some other group benefits plan (for example, Medicare or your spouse's employer medical plan), then any benefits you receive from that other plan will be "coordinated" with your TeamstersCare coverage. This includes medical, prescription drug, dental, or mental health & substance abuse benefits.

It's extremely important to understand this concept called "Coordination of Benefits" or "COB." COB provisions are routinely included in group health plans. They're designed to provide Plan participants the fullest allowable coverage, while avoiding benefit over-payment.

Important Note: ***Under COB, TeamstersCare will make certain your expenses are properly paid, but we also need to ensure that the total payments you're eligible to receive, from all your coverages combined, do not exceed 100% of the charges you're billed. By "coordinating" our own Plan with other health coverages, we create efficiencies that will often result in full coverage for you—with lower out-of-pocket costs.***

Basically, COB provisions help determine the order in which multiple parties are responsible for reimbursement in the event of a claim. To prevent a covered person from being caught in the middle of a dispute between two plans, and to provide a consistent method of deciding which plan pays first, TeamstersCare uses the National Association of Insurance Commissioners' (NAIC) guidelines to help determine the general order of benefit payment.

General COB Guidelines

In general terms, the Plan follows certain guidelines in determining whether TeamstersCare is the "primary" or "secondary" payer. In the following description, if a plan is described as "primary," it means that plan pays first. "Secondary" means that plan pays second.

Generally, benefits are determined so that if you are covered by:

- two plans from two different jobs, the plan that has covered you longer is primary
- a plan that covers you as an active employee, that plan is primary to a plan that covers you as a retired employee
- a TeamstersCare Plan, and also by a spouse's employer plan, your spouse's plan is primary for your spouse's coverage, secondary for your coverage

- two plans and only one plan has (and abides by) COB provisions, then the plan that does not have (or does not abide by) COB provisions is primary, and the plan with the COB provisions is secondary
- Medicare while still an active employee, Medicare is secondary

In cases where you are covered by COBRA as a former TeamstersCare participant, but you also have coverage under some other health benefits plan (for example, another employer's plan or your spouse's employer plan), that other plan—and not the COBRA continuation—always pays first when benefits are "coordinated."

Example: Suppose your spouse has primary coverage through his/her employer and secondary coverage through TeamstersCare. In order for TeamstersCare to pay benefits as the secondary payer, all of the TeamstersCare Plan requirements must be satisfied. In this case, for example, your spouse must obtain a referral from his/her Primary Care Physician in order to qualify for TeamstersCare secondary medical coverage.

Important Note: ***TeamstersCare will communicate with all medical, pharmacy, and dental plan options, as appropriate, regarding coordination of benefit issues.***

Exceptions to General COB Guidelines

In cases where there are exceptions to these general guidelines, TeamstersCare will determine its COB obligations on the basis of the particular facts and circumstances.

COB for TeamsterShare Payments/Co-payments

Coordination of benefits does not apply to TeamsterShare Payments for pharmacy and other TeamstersCare clinical services. HMO and Out of Area copays are not coordinated, except in the case where the primary plan has a higher copay than the TeamstersCare Plan, and you have met the requirements of both plans.

COB for TeamstersCare Pharmacies/Express Scripts/Medco

TeamstersCare Pharmacies are available only to members and eligible dependents that have TeamstersCare as primary coverage. The same is true for the Express Scripts/Medco network. This means in cases where other coverage is primary, a person is not eligible to use TeamstersCare Pharmacies or their Express Scripts/Medco card to fill prescriptions. Since the TeamstersCare Pharmacy benefit is secondary in these cases, benefits are coordinated with the primary plan. You must submit appropriate documentation and a Claim Form to Charlestown Member Services for coordination and reimbursement.

Cases of Double TeamstersCare Coverage

When both you and a spouse have primary coverage through TeamstersCare, you and your family will be enrolled in only one medical and one pharmacy plan. Your family will be enrolled under the member with the longest time at TeamstersCare. Your dental and vision benefits will be available under both members.

Coordinating Coverage for Children

If your children are covered by both TeamstersCare and your spouse's employer plan, the plans use a guideline called "the birthday rule" to determine which plan pays first for healthcare benefits provided to

your children. The birthday rule says that benefits will be paid first by the plan of the parent whose birthday occurs earlier in the calendar year.

In the case of stepchildren, if the divorce decree stipulates that the father is responsible for health care coverage, then the father's coverage is prime. If the divorce decree stipulates that the mother is responsible for health care coverage then the mother's coverage is prime. If the divorce decree makes no stipulation, then the custodial parent's coverage is prime. In cases when the parents have shared custody, the birthday rule applies and is applied to the birthdates of the natural parents.

Coordinating Coverage with Medicare

If you're an active TeamstersCare member when you or your spouse becomes entitled to Medicare at age 65, TeamstersCare will be your "primary payer." This means TeamstersCare will pay benefits before Medicare, and then Medicare will consider assuming any remaining expenses. TeamstersCare is also primary payer, for up to 30 months, for members and dependents that have permanent kidney failure.

This also applies if you have any dependents entitled to Medicare because they're disabled.

Remember that Medicare Part A coverage is automatic when:

- you or your spouse reaches age 65 and have enough quarters of covered employment

-or-

- you have a disabled spouse or dependent who has been receiving Social Security disability payments for at least two years

Prescription Drug Coverage under Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare Prescription Drug Plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare.

TeamstersCare has determined that the prescription drug coverage offered by Teamsters Union 25 Health Services & Insurance Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. This means you can keep TeamstersCare coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. You may request a Creditable Coverage Certificate by contacting Charlestown Member Services (see page 76 for contact information).

Third Party Liability

In certain instances, a "third party" may be responsible for the cost of treating an illness or injury incurred by you or an eligible dependent. A "third party" means someone other than you or the TeamstersCare Plan. It can be a person, a legal entity, or some other insurance plan (e.g., Workers' Compensation, uninsured motorists' pool, etc.).

Before TeamstersCare can process healthcare/disability expenses that might have been caused by a third party, you're required to sign an Assignment and Consent to Lien Agreement approved by the Board of Trustees. The Agreement obligates you to reimburse the Plan for any payments it has made on your behalf should you subsequently receive proceeds from a third party or from your own insurance policy. If you fail to sign the Agreement, no benefits will be paid to you. You may not release any third party that might be obligated to pay you without the Plan's written approval.

If you act on your own behalf to collect monies due from a third party, you must inform anyone involved in that transaction (e.g., your attorneys, the third party, etc.) of your obligation to reimburse the Plan, and you must include the Plan's subrogation claim in your action. TeamstersCare has priority claim to any monies you are subsequently paid by a third party—up to the full amount of the reimbursement due. In no event will fees and costs associated with this action be paid by the Plan. You must hold all recovered proceeds in trust for the Plan's benefit.

If you are obligated to reimburse the Plan, and you secure a recovery but you do not make the reimbursement, TeamstersCare can suspend your benefits and/or withhold future benefits equal to the amount due. If TeamstersCare needs to take legal action to collect any balance due the Plan, you are legally prohibited from taking any action that would interfere with the Plan's right to recover. Also, you will be liable for collection costs and reasonable legal fees.

Under certain circumstances, TeamstersCare may need to seek reimbursement directly from the third party under your name, a process called "subrogation." When this happens, the Plan is collecting on your behalf, with your authorization and cooperation. Again, in this regard, the Assignment and Consent to Lien Agreement prohibits you from interfering with the Plan's right—or any actions the Plan may take—to recover the reimbursement due. Further, the Agreement requires you to provide any assistance the Plan may request.

If the original illness or injury that led to the subrogation involves a minor child, then the child's guardian or parents are responsible for cooperating with the subrogation process. Similarly, if the illness or injury ends in the wrongful death of the member or a dependent, then the responsibility passes on to that person's personal representative.

The most common situations involving subrogation are auto accidents where someone causes injury to a member. However, this is not the only basis for recovering benefits from a third party. Recoveries can be made from a second medical policy (e.g., for medical malpractice); from a homeowner's policy (e.g., for accidents in another's home or on their property); or from general liability coverage (e.g., for a defective product, where the member incurred medical expenses for which the third party was liable).

If you or a covered dependent receives money from a third party—regardless of how such monies are classified—for expenses TeamstersCare has paid, then TeamstersCare has the right to receive that money to offset expenses the Plan has paid on your behalf. This is true whether or not these monies are sufficient to pay for all of your other expenses associated with the action of that third party. These reimbursements are to be made by the member (and/or the member's guardian or estate) up to the total amount payable to or on behalf of the member (and/or his/her guardian or estate). This includes reimbursements from:

- any policy or contract from any insurance carrier, including the member's insurer, and/or
- any third party, plan, or fund whether as a result of a judgment or settlement or otherwise

You, or anyone acting on your behalf, must not do anything to prejudice TeamstersCare's rights to this reimbursement. You must provide TeamstersCare with any instruments and papers that it requests in order to assure the Plan's rights to reimbursement.

If you fail to comply with such requests, TeamstersCare is entitled to withhold benefits, services, payments, or credits due under the Plan. TeamstersCare will be subrogated to all claims, demands, actions, and rights of your recovery against a third party or parties and/or the third party or parties' insurers (including the member's insurer) where subrogation is lawfully permitted.

The amount of subrogation will equal the total amount paid under this Plan for the illness or injury the member (and/or his/her guardian or estate) has, may have, or for which the member (and/or his/her guardian or estate) asserts a claim. This Plan will also be subrogated for attorney fees related to enforcing the Plan's subrogation rights under this provision.

As Plan participants, you and your covered dependents hereby agree that you will execute and deliver any and all instruments and papers required by TeamstersCare in order to protect the Plan's rights to subrogate as explained in this section. You must also do whatever is requested or necessary in order to fully execute and to fully protect all the Plan's rights.

Additionally, you acknowledge and agree that TeamstersCare will be reimbursed by the member (and/or his/her guardian or estate) in full before any amounts, including attorney fees incurred by the member (and/or his/her guardian or estate), are deducted from any policy, proceeds, judgments, or settlements.

You agree, on behalf of yourself and/or any covered dependents (guardians and/or estates), to notify the Plan Administrator in writing whenever benefits are paid under this Plan for any injury or illness that provides or may provide TeamstersCare subrogation rights. Failure to comply with the requirements of this provision may, at the Plan Administrator's discretion, result in a forfeiture of TeamstersCare benefits.

No-Fault Auto Insurance

If you have a medical or disability claim related to a motor vehicle or motorcycle accident, you (or someone acting on your behalf) must notify TeamstersCare as soon as possible. TeamstersCare coverage varies with a number of factors. In all cases, you will have to sign an Assignment and Consent to Lien Agreement obligating you—should you receive any third party settlements—to reimburse TeamstersCare for any money the Plan may have paid out on your behalf.

States Requiring Mandatory No-Fault Insurance

If you live in Massachusetts, or any other state with mandatory no-fault insurance, and you are covered by such insurance, then any medical claim or lost wages resulting from a motor vehicle accident are covered by the mandatory no-fault insurance. The no-fault policy will be liable for medical, prescription drug, dental benefits and/or lost wages up to the first $2,000 of expenses—or the maximum amount called for by law, whichever is greater. After this amount is paid, TeamstersCare will then cover any remaining eligible expenses, upon receipt of a signed Assignment and Consent to Lien Agreement.

If no-fault insurance is available but you decline the coverage, and you have a claim resulting from a car or motorcycle accident, you will still be responsible for the first $2,000 of expenses—or the maximum amount that no-fault insurance would have paid, whichever is greater. TeamstersCare excludes from the benefits that it provides all amounts that would have been covered had you obtained no-fault insurance.

Important Notes:

- ***If you are denied benefits from your motor vehicle insurance due to driving under the influence, TeamstersCare excludes from your benefits all amounts that would have been covered by the insurance carrier.***
- ***Mandatory no-fault insurance does not provide lost wage coverage for motorcycle accidents.***

Other States

If you live in a state that does not require mandatory no-fault coverage, the Plan will administer motor vehicle and motorcycle accident medical or disability claims in the same way as any other claim. However, if you receive any third-party settlements, you will be required to reimburse TeamstersCare an amount equal to any payments the Plan may have made on your behalf.

Workers' Compensation

TeamstersCare does not pay medical or disability benefits for a work-related illness or injury. If you are injured while on the job, your employer may be required to continue health insurance contributions to TeamstersCare at a rate of 32 hours per week for up to 12 months, if specified in your Collective Bargaining Agreement (CBA).

If you submit a Workers' Compensation claim and that claim is denied, you have the right to appeal. If your appeal is denied, you must provide TeamstersCare with a copy of the final determination notice before we can process claims.

If you submit a claim for work-related sickness or injury and your employer disputes the claim, TeamstersCare may pay you weekly disability benefits during the period your claim is under dispute. You need to submit a denial from the workers' compensation carrier, retain an attorney and dispute the denial, and sign an Assignment and Consent to Lien Agreement to reimburse TeamstersCare in full for any Workers' Compensation benefits you may subsequently receive.

The maximum weekly disability benefit you may collect is 26 weeks from the date of injury. Any payments you receive from Workers' Compensation count toward this 26-week maximum.

While a Workers' Compensation claim is pending, and during any period of disability that follows, TeamstersCare will continue to cover any eligible medical expenses you have that are unrelated to the disability so long as you remain eligible. Coverage also continues for your dependents, so long as you remain eligible.

Your Rights as a Plan Member Under ERISA

At a number of places in this Answerbook, you'll find references to "the Plan" or to "TeamstersCare." These terms refer to the benefit plan whose official name is "Teamsters Union 25 Health Services & Insurance Plan."

The Plan is administered by a Board of Trustees, according to the terms of:

- the Agreement and Declaration of Trust of the Teamsters Union 25 Health Services & Insurance Plan, and
- this Summary Plan Description (SPD)—i.e., the Answerbook and accompanying benefit vendors' subscriber certificates and benefit descriptions and
- certain Life and AD&D insurance policies.

These documents, taken together, make up the official "Plan Documents" as specified by the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has delegated certain day-to-day administrative duties to the Executive Director of the Fund.

As a participant in the Teamsters Union 25 Health Services & Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA, you're entitled to receive information about your plan and benefits. You may examine, free of charge, all the official documents related to the Plan. This includes insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor (such as detailed annual reports and Plan descriptions). These documents are available for review in the TeamstersCare Charlestown office during regular business hours.

You may obtain copies of all Plan documents—including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and a summary of any material Plan changes and updated Summary Plan Description—by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

A copy of the Plan's most recent annual report (Form 5500 Series) is available at the Public Disclosure Room of the Employee Benefits Security Administration. By law, the Plan Administrator must furnish each participant with a copy of the Plan's Summary Annual Report (SAR).

Under ERISA, you may be entitled to continue group health plan coverage if you lose eligibility for certain reasons. You may continue healthcare coverage for yourself, your spouse, or your dependents if you lose coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this Answerbook and the documents governing the Plan for the rules that apply to your COBRA continuation coverage rights. (See page 46 for details on Continuing Your Health Care Coverage Under COBRA).

The Health Insurance Portability and Accountability Act (HIPAA) offers protections for millions of America's workers that improve portability and continuity of health insurance coverage.

HIPAA protects workers and their families by:

- Providing additional opportunities to enroll in group health plan coverage when they lose other health coverage, get married or add a new dependent.
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on any health factors.
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under Federal Law.

See page 52 for details on your rights under HIPAA.

Under ERISA, you're entitled to enforce certain rights. No one—including your employer, your union, or any other person—can fire you or otherwise discriminate against you in order to prevent you from obtaining a Plan benefit or exercising your ERISA rights.

If Plan fiduciaries misuse the Plan's money, or if you're discriminated against for exercising your rights, you can ask for help from the U.S. Department of Labor or file suit in a Federal court. If you sue successfully, the court can order the other party to pay court costs and your legal fees. If you lose your suit, the court can order you to pay costs, plus certain fees, if, for example, it finds your claim is frivolous.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you can file suit in a Federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you believe you've been improperly denied a Plan benefit, in full or in part, you have a right, within certain time schedules, to:

- know why this was done
- obtain copies (without charge) of documents relating to the decision, and
- appeal any denial

If you have a claim for benefits that is denied or ignored, in full or in part, you can file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for operating a benefit Plan. These persons are called "fiduciaries." Plan fiduciaries are obligated to operate a Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be disqualified and required to make good any losses they have caused the Plan.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor, or you can file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the other party to pay these costs and fees. If you lose, or if your claim is found to be frivolous, the court may order you to pay these costs and fees.

Help With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA).

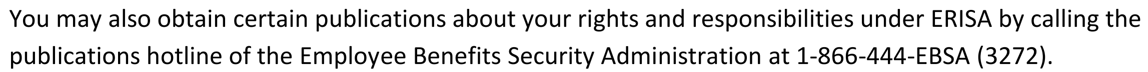
EBSA Headquarters:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-202-219-8776
Toll free: 1-866-444-EBSA (3272)

EBSA Boston Regional Office:

Employee Benefits Security Administration
Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203
617- 565-9600

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272).



Information About Teamsters Union 25 HS&IP

Plan Sponsor/Plan Administrator/Named Fiduciary

The Teamsters Union 25 Health Services & Insurance Plan is a collectively bargained employee health and welfare benefits plan, administered by a Board of Trustees that includes an equal number of union representatives and employer representatives. The Trustees serve as the "Named Fiduciary" under ERISA.

The address and telephone number for the Board of Trustees is:

Board of Trustees
Teamsters Union 25 Health Services & Insurance Plan
16 Sever Street
Charlestown, MA 02129
(617) 241-9220

The Board of Trustees

Designated by Teamsters Union Local 25:

Sean M. O'Brien, Co-Chair
President and Principal Officer
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

Thomas G. Mari
Secretary-Treasurer
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

Steven J. South
Vice-President/Business Agent
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

John A. Murphy
Business Agent
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

Designated by the Employers:

Tom J. Ventura, Co-Chair
Yellow Transportation, Inc.
10990 Roe Avenue
Overland Park, KS 66211

Joel Boone
Stop & Shop Supermarket
1385 Hancock Street
Quincy, MA 02169

Michael Rico
UPS
UPS – 1 Parcel
45 Fernwood Avenue
Edison, NJ 08837

John D. O'Reilly, Esq.
O'Reilly, Grosso & Gross
1671 Worcester Road, Suite 205
Framingham, MA 01701-5400

Plan Year

The Plan year for the Teamsters Union 25 Health Services & Insurance Plan is September 1 through August 31.

Employer and Plan Identification Numbers

The Board of Trustees' employer identification number is 04-6374631. The Plan number for all programs is 501.

Plan Contributions

Employers contribute to the Plan according to the terms of their individual Collective Bargaining Agreements (CBA) or standard participation agreements.

The collective bargaining agreements require contributions to the Plan at fixed rates. These rates are applied to the number of hours for which an employee who is covered by an agreement receives or is due pay, in some cases up to a maximum of 40 hours per week.

If you make a request in writing, TeamstersCare will provide you with a copy of your relevant collective bargaining agreement and information as to whether a particular employer is contributing on your behalf under the bargaining agreement.

Benefit Payment

TeamstersCare pharmacy, dental, vision and weekly disability benefits payments are provided from Plan assets and are not guaranteed under a policy of insurance. These assets are accumulated under the provisions of the collective bargaining and trust agreements. Medical and life insurance benefits are provided through insurance.

Eligibility for Benefits

See page 9 for detailed information on:

- benefit eligibility
- disqualification, ineligibility, denial, suspension, loss, or reinstatement of benefits

Financial Information

The Plan's assets are held in a trust fund for the exclusive purpose of providing benefits to covered participants and paying reasonable administrative expenses. Assets and reserves are invested with financial institutions in certificates of deposit, common stocks, bonds and other asset classes—all of which are authorized, approved, and administered by the Board of Trustees.

Agent for Service of Legal Process

If for any reason you wish to seek legal action, you may serve legal process upon the Plan Administrator, at the following address:

Board of Trustees
Teamsters Union 25 Health Services & Insurance Plan
16 Sever Street
Charlestown, MA 02129
(617) 241-9220

Plan Authority

The Board of Trustees has the right to administer the Plan at its sole discretion. This includes the right to make binding and conclusive determinations regarding:

- who is eligible for benefits
- the amount of benefits payable
- the meaning and applicability of Plan provisions

Similarly, the Board of Trustees reserves the right to amend, modify, reduce, or discontinue all or part of the Plan, according to the terms of the Plan and Trust Agreement, by appropriate action, including:

- changing any amounts contributed to the cost of providing benefits
- changing the level of benefits provided
- changing the class or classes of individuals eligible for benefits
- terminating the Plan in its entirety or with respect to any covered class or classes

Only the Plan Trustees may interpret Plan provisions, including: determining eligibility for benefits and the right to participate in the Plan; how hours are credited; eligibility for any benefit; discontinuing benefits; status as a covered or non-covered employee; benefit levels; and interpreting the rules with respect to a particular claim or application.

No one is authorized to speak on behalf of, or to commit the Trustees on, any Plan-related matter, without the expressed authority of the Trustees. This includes local union officers, business agents, local union employees, employers or employer representatives, TeamstersCare office personnel, consultants, or attorneys.

Claims and Appeals

Under certain circumstances, you may need to file a benefit claim. A claim is any request for a Plan benefit, made by a claimant or by a representative of the claimant that complies with the Plan's reasonable procedure for making benefit claims.

Submitting a Claim

Claims procedures vary somewhat, depending on the benefit involved. If you intend to submit a claim, first check the appropriate section of this Answerbook and refer to page 72 for some useful definitions. If you need further information, call Charlestown Member Services (see page 76 for contact information).

Outline of Claims Procedures

If you have a claim for:	*You must submit the itemized bill or proof of death or disability within this amount of time:*	*In cases where a claim form is required:*	*Return the form to:*	*Comments:*
TeamstersCare HMO Blue N.E.	Providers file claims directly to Blue Cross. Member claims must be submitted within 12 months from the date of service.			
TeamstersCare Blue Care Elect (Out of Area option)	Providers file claims directly to Blue Cross. Member claims must be submitted within 24 months from the date of service.			
Prescription Drug	12 months from the date of service	Express Scripts/Medco	Express Scripts/Medco	You're required to submit a prescription drug claim when you use: a non-network pharmacy, or a network pharmacy if you have not supplied your Medco/Express Scripts insurance information

Outline of Claims Procedures				
If you have a claim for:	*You must submit the itemized bill or proof of death or disability within this amount of time:*	*In cases where a claim form is required:*	*Return the form to:*	*Comments:*
Dental	12 months from the date of service	Obtain the form at your dentist's office or call BCBS Customer Service	Blue Cross Blue Shield of MA	You're required to submit a dental claim when you use a non-network provider
Hearing Out of NE benefit after pretreatment review and approval	12 months from the date of service, if pretreatment review was submitted	Call Charlestown Audiology Office	Charlestown Audiology Office	You're required to submit an Audiology claim for services authorized by TeamstersCare but provided outside of New England
Weekly Disability	90 days from the date of disability	Call Charlestown Member Services	Charlestown Member Services	A Disability Claim Form must be completed by the member and the doctor
Life Insurance	12 months from the date of death	Call Charlestown Member Services	Charlestown Member Services	The person filing the claim must also provide a certified copy of the death certificate
AD&D	90 days from the date of loss	Call Charlestown Member Services	Charlestown Member Services	The person filing the claim must also provide required and appropriate documentation

Claims Filing Information		
Name	**Address**	**Telephone**
Charlestown Member Services for general claims questions	Teamsters Union 25 Health Services & Insurance Plan 16 Sever Street Charlestown, MA 02129-1309	local: (617) 241-9220 in MA: 1 (800) 442-9939 outside MA: 1 (800) 225-6135
Dental Blue Freedom	BCBS of MA P.O. Box 986030 Boston, MA 02298	1 (800) 241-0803
HMO Blue New England	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131	1 (800) 241-0803
Blue Care Elect Preferred	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131	1 (800) 241-0803
Express Scripts/Medco	Express Scripts PO Box 747000 Cincinnati, OH 45274-7000	1 (877) 543-7097

Claim Determinations and Appeals

Following are the procedures governing claim determinations and claim appeals. Note that there are different types of claims and each has specific rules, timeframes, and procedures associated with it. For claims and appeals of an insured benefit or other health benefits provided by an insurance company you must follow the specific procedures set forth in the underlying insurance policy.

An **"Urgent Care Claim"** is any claim for care or treatment where using the timetable for non-urgent care determination could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is being requested.

A **"Pre-Service Claim"** is any claim for a health benefit (other than an Urgent Care Claim) that, per the terms of the Plan, must be approved before care is obtained.

A **"Post-Service Claim"** is any claim for a Plan benefit that is for services already received by the claimant.

"Adverse benefit determination" is any of the following: a denial, reduction, termination of or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Timing of Notification of Claim Determinations

The amount of time that the Plan will take in making a claim determination will be governed by the nature of the claim.

Urgent care claims – In the case of an urgent care claim, the Plan will make the benefit determination (whether adverse or not) as soon as possible but not later than 72 hours after receipt of the claim. In the case of requests for additional treatments or periods of time involving urgent care, the Plan will make the benefit determination (whether adverse or not) within 24 hours after receipt of the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service non-urgent care claims – In the case of a pre-service non-urgent care claim, the Plan will notify you of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Post-service non-urgent care claims – In the case of a post-service non-urgent care claim, the Plan will notify you of the adverse benefit determination within a reasonable period of time but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters

beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Weekly Disability Claims – In the case of a weekly disability claim, you will be notified of the status of your claim within 45 days after the Plan receives your claim. If additional time is needed to respond to your claim (due to matters beyond the control of the Plan), you will be notified before the end of the initial period and then receive a response within 30 days after the end of the original 45-day deadline. An additional 30-day extension may be required. If requested, you must provide any additional information within 45 days after you are notified that the Plan needs additional information.

Other Type of Claims – In the case of any other claim not referenced previously, you will be notified of the status of your claim within 90 days after the Plan receives your claim. If additional time is needed to respond to your claim (due to matters beyond the control of the Plan), you will be notified before the end of the initial period and then receive a response within 90 days after the end of the original 90-day period.

Manner and Content of Notification of an Adverse Benefit Determination

You will be furnished with written or electronic notification of any adverse benefit determination. The notification will include the following information:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provision upon which the determination is based;
- If applicable, a description of any additional material or information necessary from you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- When applicable, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request;
- When applicable, if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- When applicable, in the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such a claim.

Appeal of Adverse Benefit Determinations to the TeamstersCare Board of Trustees

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the initial adverse benefit determination. To appeal insured benefits or any other health benefit provided by an insurance carrier, you must follow and have exhausted all grievance procedures under the insurance policy.

The Plan has established and maintains a procedure through which you will be afforded a full and fair review of an adverse benefit determination. That procedure:

- Provides you 180 days to appeal an adverse benefit determination following receipt of the adverse notification.
- Provides you the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.
- Provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.
- Provides that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- Provides that the health care professional engaged for purposes of consultation on the appeal shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- Provides, in the case of a claim involving urgent care, for an expedited appeal of an adverse benefit determination by which information can be submitted and transmitted orally or by facsimile or other available expeditious methods.

Timing of Notification of Benefit Determinations on Appeal to Board of Trustees

The Board of Trustees at their next regularly scheduled meeting will make a determination of an appeal. If the appeal is received less than 30 days before the scheduled meeting, the decision may be scheduled for the second meeting following receipt of the request.

Content of Adverse Benefit Determination on Appeal

The Plan's written notice of the Board of Trustee's decision will include the following:

- The specific reasons for the adverse benefit determination;
- Reference to specific plan provisions on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that

a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Board of Trustees Decision is Final and Binding

The Board of Trustees (or their designee's) final decision with respect to their review of your appeal will be final and binding. The Board of Trustees has exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan.

Any legal action against the Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Final Notes

If you have questions about your benefits, or if you do not understand the Plan because of language limitations, contact TeamstersCare for help—or have someone do this for you.

The Answerbook is designed to make your benefits as clear to you as possible. However, nothing written in the Answerbook is meant to reinterpret, add to, or change in any way the legal provisions expressed in the Plan and in the Agreement and Declaration of Trust or in any insurance policies purchased by Teamsters Union 25 Health Services & Insurance Plan.

Important Addresses and Phone Numbers

Teamsters Union 25 Health Services & Insurance Plan		
In Charlestown: Main Office Member Services Office Dental Office Audiology Office Board of Trustees Employee Assistance Program	16 Sever Street Charlestown, MA 02129-1305	Local: **(617) 241-9220** In MA: **1 (800) 442-9939** Outside MA: **1 (800) 225-6135** Fax: (**617) 241-8168** website address: **www.teamsterscare.com** **Hotline: 1 (800) 851-8326**

Medical Benefit Options		
TeamstersCare HMO Blue New England	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131	**1 (800) 241-0803** website for general information: **www.bcbsma.com**
TeamstersCare Blue Care Elect Preferred	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131	to call Customer Relations: **1 (800) 241-0803** to check for Blue Care Elect Preferred providers: **1-800-810-2583** website for general information: **www.bcbsma.com**

TeamstersCare Walk-in Pharmacies		
In Charlestown:	552 Main Street Sullivan Square Charlestown, MA 02129-1114	Local: **(617) 241-9024** Toll free: **1 (800) 235-0760** Fax: **(617) 241-5025**
In Stoughton:	1214 Park Street Stoughton, MA 02072	Local: **(781) 297-9764** Fax: **(781) 297-9370**

TeamstersCare Audiology Office		
In Charlestown:	16 Sever Street Charlestown, MA 02129-1305	Local: **(617) 241-9220** In MA: **1 (800) 442-9939** Outside MA: **1 (800) 225-6135**

TeamstersCare Dental Offices		
In Charlestown:	16 Sever Street Charlestown, MA 02129-1305	Local: **(617) 241-9220** In MA: **1 (800) 442-9939** Outside MA: **1 (800) 225-6135**
In Chelmsford:	4 Meeting House Road Chelmsford, MA 01824	Local: **(978) 256-9728** Toll free: **1 (800) 258-2111**
In Stoughton:	1214 Park Street Stoughton, MA 02072	Local: **(781) 297-7360** Toll free: **1 (877) 326-1999**

TeamstersCare Employee Assistance Program		
In Charlestown:	16 Sever Street Charlestown, MA 02129-1305	Phone: **1 (800) 851-8326** Fax: **(781) 321-6501**

Modern Assistance Programs, Inc.	
1458 Hancock Street, 3rd Floor Quincy, MA 02169	Phone: **(617) 774-0331** Fax: **(617) 774-0336**

Dental Care		
Dental Blue Freedom	Contact BCBS Customer Service to: -obtain a claim form (if not available from your dentist) -determine whether a particular dentist is in Dental Blue PPO, Dental Blue Traditional, or the Dentemax network	BCBS Customer Service **1 (800) 241-0803**
	Mail claim forms to: BCBS MA P.O. Box 986030 Boston, MA 02298	
	website for general information	**www.bluecrossma.com**

Life Insurance and AD&D	
United of Omaha Life Insurance Mutual of Omaha Plaza Omaha, Nebraska 68175	Customer Service & General Information: **1 (800) 775-8805**

Vision Care		
Davis Vision	- to find a provider	Customer Service **1 (800) 999-5431**
	website for general information	**www.davisvision.com**

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