EARLY RETIREE MEDICAL PROGRAM SUMMARY PLAN DESCRIPTION

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

July 2019

A Letter from the Board of Trustees

Dear TeamstersCare Retiree:

As an eligible retiree of the Teamsters Union 25 Health Services & Insurance Plan (TeamstersCare), you may participate in the TeamstersCare Early Retiree Medical Program which provides health benefits for retirees, their spouses, and eligible dependents.

You are eligible for this Program by virtue of your age and your years of credited service when you retired. The Program provides valuable benefits for you and your family when you need medical, pharmacy, dental, vision, hearing, mental health and substance abuse services.

In addition to the comprehensive healthcare services available to you from our dedicated third-party providers, you and your eligible dependents have access to our TeamstersCare Dental Offices in Charlestown, Stoughton, and Chelmsford, to our Pharmacies in Charlestown and Stoughton, to our Audiology and Employee Assistance Program (EAP) Offices in Charlestown and Wellness Programs. We are pleased to provide these Clinical In-House services for a reasonable TeamsterShare payment or, in some cases, at no cost to you.

This is a Summary Plan Description (SPD), a document designed to communicate, in understandable language, the basic details of your TeamstersCare Early Retiree Medical Program. TeamstersCare administers the Program according to the terms of this SPD and the Agreement and Declaration of Trust of the Teamsters Union 25 Health Services & Insurance Plan.

The Board of Trustees is pleased to provide you with this updated description of your retiree benefits and encourages you to read this booklet carefully and make certain that your family understands how they can use the SPD to find important information about your benefits. If you have questions on any aspect of your benefits you may visit us in person at any of our facilities, check our website at **www.teamsterscare.com** or contact TeamstersCare through Charlestown Member Services, at the following phone numbers:

Local:	617-241-9220, ext 2
Toll Free in MA:	800-442-9939, ext 2
Toll Free outside MA:	800-225-6135, ext 2

Please remember that no question that you or your dependents may have is too basic to ask—or too much trouble for us to answer.

Board of Trustees

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Introduction

The TeamstersCare Early Retiree Medical Program provides healthcare benefits ***for retirees and their spouses under age 65, and their eligible dependents.***

If you're an eligible TeamstersCare retiree covered by this Program, you, your spouse and your eligible dependent children have the following healthcare benefits:

- Medical care, including hospitalization
- Pharmacy and prescription drugs
- TeamstersCare In-House dental care
- TeamstersCare In-House hearing care
- TeamstersCare Employee Assistance Program
- Vision care
- Wellness programs (members and spouses only)

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.

Important Note: ***For retirees and spouses age 65 and over***, TeamstersCare offers two programs:

- **The Retiree Prescription Drug Program** – includes pharmacy benefits, TeamstersCare In-House dental and hearing care, vision care through Davis Vision and certain wellness programs
- **The TeamstersCare Retiree Clinical Services and Vision Program** – includes TeamstersCare In-House dental and hearing care, vision care through Davis Vision and certain wellness programs

Dependent children are not eligible for coverage in the over age 65 Retiree Programs. For more details regarding the Retiree Prescription Drug Program or the Retiree Clinical Services and Vision Program, please see the separate Plan documents pertaining to those Programs—or call Charlestown Member Services.

If a retiree enrolled in the TeamstersCare Retiree Medical Program turns age 65 and decides not to enroll, or discontinues coverage in either the TeamstersCare Retiree Prescription Drug Program or the TeamstersCare Retiree Clinical Services and Vision Program, his/her eligible dependents may continue coverage in the TeamstersCare Retiree Medical Program.

If you have questions regarding specific coverage that you can't find described in this benefit booklet, don't hesitate to call Charlestown Member Services. See page 56 for this and other important phone numbers.

The Patient Protection and Affordable Care Act

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

Your eligibility for the Early Retiree Medical Program depends on four determining factors, all related to the date you were last covered by the Active TeamstersCare Medical Benefit Program.

As of the date referenced above, eligibility is dependent upon:

❶ your age, and

❷ the years of credited service you have accumulated (please see definition on page 7)

Furthermore, as of that date, the following is required:

❸ you must have been covered by the Active TeamstersCare Medical Program for at least 36 months out of the last five years (60 months), and

❹ your employer must have made contributions to the Active TeamstersCare Medical Program on your behalf for at least ten years (120 months)

Important Note: Contributions to the Active TeamstersCare Dental and Vision Program do not count toward the 120 month requirement.

Age Requirement

You're eligible for the Early Retiree Medical Program if, as of the last day of coverage under the Active TeamstersCare Medical Program, you have:

- **15 or more years of credited service and you're age 60 or older**, or
- **20 or more years of credited service and you're age 55 or older**, or
- **30 or more years of credited service at any age**

The age requirement may be waived if, as of the last day of coverage under the Active TeamstersCare Medical Program, you:

- are permanently and totally disabled as determined by Social Security, and
- have 15 or more years of credited service.

In this case, you become immediately eligible for the Early Retiree Medical Program.

Your spouse and qualified dependent children become eligible to join the Early Retiree Medical Program on the same date that your own coverage begins.

Years of Credited Service

Years of credited service can include:

- your years of pension credit under the New England Teamsters & Trucking Industry Pension Plan or the Central States Pension Fund, or
- your years of coverage under the Active TeamstersCare Medical Program, or
- any combination of separate periods for these two which add up to the required number of years

Enrollment

If you intend to join the Early Retiree Medical Program (whether immediately or on a deferred basis), you must provide written notification to Charlestown Member Services within 30 days of the date that you first become eligible for this Program.

In most cases, you'll likely choose to join the Early Retiree Medical Program as soon as you become eligible. However, if you're covered under another group health plan when you first become eligible for the Early Retiree Medical Program, you can defer joining the Program—but there are certain very specific conditions that must be fulfilled in order for you to enroll, on a deferred basis, at a later date. (See "Special Enrollment Under HIPAA," immediately following.)

Special Enrollment Under HIPAA

As a TeamstersCare retiree, you have special enrollment rights available to you under a federal law called The Health Insurance Portability and Accountability Act (HIPAA).

If you or your dependents become eligible for TeamstersCare retiree benefits but decline coverage because you have other group health coverage, you may reapply for the TeamstersCare Early Retiree Medical Program if you subsequently lose that other coverage. However, in order to be eligible for this special enrollment, you must meet each of the following conditions:

First,

- You have other group health coverage, such as an employer-sponsored plan (not a government sponsored health plan), or COBRA at the time TeamstersCare first offers you retiree coverage, and
- You provide written notification ("deferral") to TeamstersCare at such time that this other coverage is the reason you are declining enrollment.

And then,

- You become ineligible for your "other group health coverage," -or-
- You elected COBRA continuation when you first declined TeamstersCare retiree coverage, but your COBRA coverage has ended.

Furthermore, in order to be eligible for these special deferred enrollment rights:

- You must request the special enrollment within 30 days of losing coverage under the other plan, and
- You must provide proof that your other coverage has ended.

If you request special enrollment—and are otherwise eligible for TeamstersCare retiree benefits—your coverage begins no later than the first day of the month following your application.

If, after you become eligible for special deferred enrollment, you then have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependent in this Program. Coverage for the new dependent starts on the date of the marriage, birth, adoption, or placement for adoption, as long as all enrollment materials and documentation are provided within 30 days of the event. If more than 30 days have passed since the event occurred, coverage for the new dependent will begin on the first of the month in which the documentation is received.

Important Note: If the addition of a dependent to your Program results in an increase to your premium, payment must be made before coverage will be activated.

Dependent Eligibility

When Your Dependents Are Eligible

Your eligible dependents who are enrolled in your TeamstersCare Early Retiree Program are also entitled to medical, prescription drug, dental, vision, hearing, and the Employee Assistance Program benefits.

"Eligible dependents" may include:

- Your current spouse
- Your ex-spouse, in cases where:
  - your ex-spouse was covered by the Plan at the time of divorce, and
  - you have a divorce decree requiring you to cover your ex-spouse, and
  - if you remarry, 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 all current and future coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other coverage.
- Your Eligible Children (see definition below) up to the last day of the month the dependent turns age 26
- Your Disabled Children (see definition, page 10) aged 26 and older

Important Notes:

If you maintain coverage for your ex-spouse and your ex-spouse remarries, your ex-spouse is no longer an eligible dependent and coverage for your ex-spouse ends.

You cannot cover a spouse and an ex-spouse at the same time.

Defining "Eligible Children"

"Eligible children" include the following, up to age 26: your natural children; dependent children of your dependent; 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; foster children. Eligibility ends with the termination of guardianship or foster care. TeamstersCare also covers the retiree'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 turning age 26 and, at that time, the child must be:

- covered by the Plan and
- mentally or physically disabled on the date eligibility would normally end.

In order for your dependent to be eligible for continued medical coverage, you must notify TeamstersCare within 30 days after the disabled child turns 26. TeamstersCare will help you with required documentation and coordination 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.

Continuing Coverage for Your Spouse after Divorce

In the event of divorce, 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. 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 31 days of your divorce becoming final.

If coverage is extended and your ex-spouse subsequently remarries, his/her coverage ends the day before the remarriage. **You, as the retiree, 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 all coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other health coverage. Under the Plan, you cannot cover a current spouse and an ex-spouse at the same time.

If, upon your divorce, you are not required to provide coverage to your ex-spouse, he/she may be eligible to purchase temporary extended healthcare coverage under COBRA for up to 36 months (see page 29 for details of COBRA coverage for dependents).

You, as the retiree, are responsible for notifying your ex-spouse of all benefit updates and changes, as well as providing your ex-spouse with ID cards and relevant benefit literature.

After a divorce, a step-child or a child for whom your ex-spouse was the sole legal guardian who was enrolled in the plan is no longer considered an eligible dependent and therefore is no longer eligible for benefits as of the date of divorce.

Important Note: Divorce 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 you may incur beyond that 31 day period. **Any claims paid for an ex-spouse who is considered an ineligible dependent after the divorce or remarriage date will be the member's responsibility, unless TeamstersCare has a court order on file requiring coverage of the ex-spouse.**

Coverage in the Event of Death

In the event of the death of an Active TeamstersCare member who, as of the date of death, is eligible to retire and has a minimum of 15 years of credited service:

- the member is considered to have retired as of the last day of eligibility under the Active Program, and
- the member's spouse may be eligible to enroll in either the Early Retiree Medical Program, the Retiree Prescription Drug Program, or the Retiree Clinical Services and Vision Program, based on the spouse's age, and
- the member's dependent children may be eligible to enroll in the Early Retiree Medical Program

When Eligibility Ends

Member Eligibility

As the member, your eligibility for the Early Retiree Medical Program ends on the earliest of the following:

- the first day of the month in which you reach age 65
- the date the Program's grace period ends for any required contributions to be paid
- the date you work more than the allowed number of hours per month in covered employment (currently 80 hours for retirees under age 70)
- the date you voluntarily discontinue coverage
- the deadline to request deferred enrollment passes (30 days after losing entitlement to group health coverage)
- the date the Program terminates

Spouse's (or Ex-Spouse's) Eligibility

Your spouse's (or ex-spouse's) eligibility for the Early Retiree Medical Program ends on the earliest of the following:

- the first day of the month in which he or she reaches age 65
- the date the Program's grace period ends for any required contributions to be paid

- the date you, as the retiree, work more than the allowed number of hours per month in covered employment (currently 80 hours for retirees under age 70)
- the deadline—more than 30 days after losing coverage under another group plan— for requesting deferred enrollment
- the date you as the retiree remarry
- the date your ex-spouse or widow(er) remarries
- the date the Program terminates

Dependent Child's Eligibility

Your dependent child's eligibility for the Early Retiree Medical Program ends on the earliest of the following:

- the last day of the month the dependent reaches age 26 (see exceptions for disabled children, page 10)
- the date the Program's grace period ends for any required contributions to be paid
- the date you, as the retiree, work more than the allowed number of hours per month in covered employment (currently 80 hours for retirees under age 70)
- the deadline—more than 30 days after losing coverage under another group plan—for requesting deferred enrollment
- the date the Program terminates

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 **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. The TeamstersCare website, **www.teamsterscare.com**, has a list of states with their contact information for the Medicaid and CHIP Offices.

Your Share of the Costs

TeamstersCare partially subsidizes the cost of your Early Retiree Medical Program. You make your own contribution for the balance of your cost through monthly payments. The amount of your contribution depends on your age at retirement and the date of your retirement, as follows:

- under age 60 and retired on or before April 1, 2002, or
- age 60 through 64 and retired on or before April 1, 2002, or
- under age 65 and retired after April 1, 2002

For members retiring on or after April 1, 2002, the amount of the TeamstersCare monthly subsidy provided toward your coverage in the Early Retiree Medical Program is based on ***your age and your years of credited service*** according to the following schedule. Please see page 7 for additional information on years of credited service.

Monthly TeamstersCare Subsidy* Schedule for Members Entering the TeamstersCare Early Retiree Program On or After April 1, 2002

***The subsidy is the amount the Plan contributes toward your medical program**

	Years of Credited Service at Retirement			
Age at Retirement	**15-19**	**20-24**	**25-29**	**30+**
under 55	N/A	N/A	N/A	$424
55-56	N/A	$424	$424	$424
57-59	N/A	$424	$474	$554
60-64	$424	$448	$501	$659

(Note: If you retired before 4/1/2002, please contact TeamstersCare Member Services for the applicable subsidy schedule.)

Important Note: The Monthly TeamstersCare Subsidy amount will not change; if costs increase, your retiree contribution amount will change.

The exact dollar amount of your monthly contribution is determined by a number of factors, most importantly the prevailing costs of health care for persons of retirement age. Each year, the Trustees review these external factors as well as the overall financial condition of the Fund and set contribution rates accordingly. When rates change, TeamstersCare advises you by mail. For current contribution amounts, please call Charlestown Member Services.

You contribute on a per person, per month basis. “Person” means you, as the retiree, or your spouse or other dependent. The most you have to pay for the Early Retiree Medical Program in any one month is two times the highest contribution you’re making for any one person. Once

you reach that family dollar maximum, TeamstersCare subsidizes the remaining cost for all other eligible dependents in your family.

Any contributions you may make for Retiree Prescription Drug Program or Retiree Clinical Services and Vision Program coverage —for either member or spouse—do not count towards this Early Retiree Medical Program family dollar maximum. In other words, a family with dependent coverage could conceivably be required to contribute the family dollar maximum for Early Retiree Medical Program coverage (i.e., twice the cost for one person), plus—separately—the Retiree Prescription Drug Program contribution.

Important Note: If you collect a monthly pension from the New England Teamsters & Trucking Industry Pension Fund, your monthly health care contribution will be automatically deducted from your New England Teamsters & Trucking Industry pension check.

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
- a change in your address or the address of an eligible dependent
- marriage, divorce, 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; any change in your own or your dependent's employment-related healthcare coverage
- eligibility for Medicare and/or Social Security disability status

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 56 for contact information). TeamstersCare may require that you submit additional documentation at the time you notify us of the change.

TeamstersCare manages all eligibility and enrollment issues. Anytime you provide us with eligibility-related information that also affects your benefit vendors (such as Blue Cross Blue Shield or Davis Vision), we will communicate with them 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 repaying a lien after you receive a monetary award for an illness or injury covered by the Plan
- not repaying the Plan after you have received proceeds from a third party for an illness or injury covered by the Plan
- not responding to a request for information
- not submitting an *Enrollment Form* when TeamstersCare requires you to do so
- enrolling an ineligible dependent
- failing to repay claims paid for an ineligible dependent
- committing fraud or misrepresenting information to TeamstersCare
- a check for a TeamsterShare Payment is returned from your bank as unpaid
- paying less than the required retiree contribution amount

TeamstersCare Early Retiree Medical Benefits

Overview of Medical Benefits

TeamstersCare provides medical benefits through a Health Maintenance Organization (HMO) and an Out of Area benefit plan. Both plans are offered through Blue Cross Blue Shield of Massachusetts (BCBS). The current options are:

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

Each of these options offers a wide range of health services, including coverage of doctors' visits, hospitalization, surgery, maternity care, behavioral health and substance abuse treatment—and many other medical products and services.

Your coverage option depends on where you live. You must participate in the HMO if you and all of your eligible dependents permanently reside within the TeamstersCare HMO Blue New England network service area. If you or any one of your eligible dependents **permanently** resides in an area not covered by the HMO, then you and all your dependents will be covered by the TeamstersCare Blue Care Elect Preferred Out of Area Option. If you're a member of TeamstersCare HMO Blue New England, you and each covered family member will need to

select a Primary Care Provider (PCP). 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 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 individual/$500 family deductible. The out of network calendar year 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 eligible dependents permanently live in the New England area, then you must call Charlestown Member Services to change 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, you and your dependents will continue to be covered by your HMO option.

TeamstersCare HMO Blue New England:

For specific details of your HMO coverage, go to www.BCBS.MA.com or www.teamsterscare.com. In general:

- You'll select a Primary Care Provider (PCP)—the individual professional who's principally responsible for coordinating your medical care. Visit **www.bluecrossma.com** for physicians in your area. Your current doctor might 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.

TeamstersCare Blue Care Elect Preferred Out of Area Option

If you or 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, visit **www.bluecrossma.com** or call **1-800-810-2583**.

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 payment 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. The out of network calendar year maximum is $1,000 per individual /$2,000 per family. (These are the maximum amounts you will pay out of your pocket each year.)

For more information on the Blue Care Elect Preferred option, including claims-related questions and limitations that might apply to services, call **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, and 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 copay or coinsurance for your visit.

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 for assistance. The phone number, which is also listed on your ID card, is as follows:

- HMO Blue New England Behavioral Health & Substance Abuse: 1 (800) 444-2426
- Blue Care Elect Preferred Behavioral Health & Substance Abuse: 1(800) 524-4010

You may also access their web-site at **www.bluecrossma.com** and go to the Find-A-Doctor directory to locate a provider.

Clinical In-House 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 – through TeamstersCare and Express Scripts/Medco
- Dental care
- Hearing care
- Employee Assistance Program (EAP)
- Wellness Programs - flu shots, etc. (Member and spouse only)

Important Note: These services are made available to you through TeamstersCare—not through BCBS.

Pharmacy Benefits

Under the TeamstersCare plan, you and your eligible dependents have four options available 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 e-prescribe your prescription to the TeamstersCare Pharmacy
- ✓ have your doctor call in the prescription to the TeamstersCare Pharmacy
- ✓ have your doctor fax the prescription to the TeamstersCare Pharmacy
- ✓ ask the TeamstersCare Pharmacist to call your doctor on your behalf

Refilling Your Prescription at TeamstersCare is Easy

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 Pharmacies. 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.

PocketRx … Download the PocketRx 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 PocketRx, visit our website at **www.teamsterscare.com** or contact one of our TeamstersCare Pharmacies.

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

*Charlestown Pharmacy hours: Walk-in Service**

- Monday through Thursday — 8:00 a.m. to 6:00 p.m.
- Friday & 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 Pharmacy 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 medication 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 the U.S. mail for a $5 (generic)/$15 (brand name) copayment. Effective April 2012, Medco became 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 22 for a Prescription Drug Costs Chart detailing drug costs at a retail network pharmacy).

Option #4: Non-Network Retail Pharmacies

You can use a non-network retail pharmacy, but you'll be required to pay the full amount of your prescription at the point of sale, including the appropriate copay. You should then:

Submit a claim form – within 12 months – to Express Scripts, PO Box 2872, Clinton IA 52733-8272. Be sure to include an itemized receipt listing the amount paid. Express Scripts 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 and/or coinsurance.

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 as well as 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 a larger 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 can 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 a new medication, you haven't paid a 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:

Aciphex	Lescol
Botox	Lovaza
Crestor	Protonix
Daytrana	Nexium
Growth Hormone	Solarez

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 certain high cost prescription medications that treat complex conditions. 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 through mail order	
…at a Network retail pharmacy (up to 30-day supply)		
generic medication	$15 + 20% of remaining discounted Express Scripts/Medco cost	100% of the remaining cost
brand name medication—and no generic is available	$25 + 20% of remaining discounted Express Scripts/Medco cost	
brand name medication—and generic is available	$25 + 20% of remaining discounted Express Scripts/Medco cost + cost difference between brand name & generic	100% of the remaining cost for the generic
…at a Non-network retail pharmacy (up to 30-day supply)		
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, 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 and/or coinsurance. Please see instructions on page 20.		

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

Some examples of prescriptions TeamstersCare does not cover:

- any medication available without a prescription, except insulin
- Minoxidil—or other treatments for hair loss
- Relenza
- Prozac weekly
- Sarafem
- 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
- certain other medications not covered by the Plan – call a TeamstersCare Pharmacy for a list or go to **www.teamsterscare.com** (see page 57 for the TeamstersCare Pharmacy phone numbers).

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 (limited to 20 doses per 30 days or 60 doses for 90 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

Your TeamstersCare retiree dental benefit provides you with a broad range of general dental services. These services are available only through the TeamstersCare Dental Offices in Charlestown, Chelmsford and Stoughton.

TeamstersCare Dental Offices

You can use our In-House Charlestown, Chelmsford, or Stoughton, MA facilities for your dental care—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.

TeamstersCare Dental Offices are staffed by professional dentists, hygienists, and dental assistants. Some of our TeamstersCare dentists teach 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—as 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 at 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:

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
- do not call at least 24 hours ahead of time to cancel

TeamstersCare Employee Assistance Program (EAP)

TeamstersCare offers members and dependents an Employee Assistance Program (EAP) benefit. This program offers advice and guidance for any behavioral health issue. 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
- ✓ Substance Abuse Issues

Advice or Guidance with:

- Personal problems
- Family and Relationships
- Financial and Legal concerns
- Panic, anxiety & stress
- Life status changes, such as retirement
- Child emotional or autism issues
- Grief counseling
- Gambling issues
- 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 firmly 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 Treatment") consisting of a group of volunteers helping their fellow members and retirees 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 eligible dependent children can have comprehensive hearing testing done at the Charlestown Audiology Office 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 you or your eligible dependents (age 3 and up) please call our TeamstersCare Charlestown appointment desk at 617-241-9220 ext. 1.

Vision Benefit

TeamstersCare has contracted with Davis Vision to provide eye care benefits to you and your family 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.

Your TeamstersCare Vision Benefit

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

- 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

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

or

- contact lenses, for a $25 copay

Important Note: When choosing either glasses or contacts, you must make your full selection at the time you have your authorized eye examination. If you go to a provider who only provides an exam because the office does not dispense eyeglasses, you must order glasses through another provider within 30 days of your vision exam.

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

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 options for eyeglasses differ for you and your dependents:

You, as the **retiree member**, can receive two pairs of eyeglasses during any consecutive 24-month period. You must select the two pairs at the time of your examination. The following options apply to the combinations you can select:

- Prescription lenses—you 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).

- Your **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 in any combination of lenses. 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, visit www.davisvisioncontacts.com or call 855-589-7911.

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: Aside from the Davis Vision discount, laser vision correction surgery is not a covered benefit.

Making an Appointment

To schedule a vision exam, contact a local Davis Vision provider's office directly. To locate a Davis Vision provider, you may call 1-800-000-5431 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. You can also check your eligibility for services by calling 1-800-999-5431 or visiting the website and logging into your account.

If you need a Davis Vision Provider list or more information about your vision benefit, call Charlestown Member Services.

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

Administration

Continuing Health Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), spouses and dependents of retirees covered under a healthcare plan have the option to continue coverage under the Plan for up to three years if they lose coverage as a result of any of the following qualifying events:

- divorce
- a dependent child's ceasing to be a "dependent" as defined by the Plan

In order to elect COBRA coverage under any of these circumstances, the spouse or dependent must notify TeamstersCare within 60 days of the qualifying event.

Under COBRA, your dependents can maintain their current TeamstersCare Early Retiree Medical health coverage (i.e., under the TeamstersCare Retiree HMO Network Blue or the TeamstersCare Retiree Blue Care Elect Preferred Out of Area Option).

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 your dependents elect COBRA, they can choose one of two levels of coverage:

- ***Level #1:***
  medical benefits, prescription drug coverage, hearing care, and mental health & substance abuse benefits

  or

- ***Level #2:***
  medical benefits, prescription drug coverage, hearing care, mental health & substance abuse benefits, *plus In-House dental and vision care benefits*

Once they elect one of these two levels, they cannot change their decision during their period of COBRA coverage.

Cost of Continued Coverage

Your spouse and your covered dependents will be required to pay up to 102% of the full cost of coverage continued under COBRA as may be determined by TeamsterCare. Payment is made in monthly installments.

The first payment is retroactive to the date of the qualifying event. This first payment will be due no later than 45 days after the date continued coverage is elected. After they have paid this first premium, they need to continue making payments by the first of every month. However, each month, they have a 30-day grace period in which to pay their premium.

During a premium-payment "grace period":

- eligibility cannot be confirmed nor any claims processed until the premium has been paid and
- prescriptions cannot be filled at a TeamstersCare or an Express Scripts/Medco pharmacy

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, TeamstersCare will let you know ahead of time. For current coverage costs, contact Charlestown Member Services (see page 56 for contact information).

Period for Deciding about COBRA Coverage

Your eligible dependents must complete and return the COBRA Form to TeamstersCare sometime within 60 days of the later of two dates:

- the date they receive notice of their rights to continue coverage under the Retiree Program, or
- the date TeamstersCare coverage ends

When COBRA Continued Coverage Ends

Coverage that has been continued under COBRA ends if:

- the Program terminates for all retirees or stops offering dependent coverage
- the last day of maximum COBRA coverage is reached (36 months)
- premiums are not paid within the specified time limit
- coverage is obtained under another group health plan (unless this other plan limits or excludes coverage for pre-existing conditions)

Special Enrollment Rights

In considering whether to elect continuation coverage, your dependents should take into account that they have special enrollment rights under federal law. They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after group health coverage ends because of the qualifying event listed above. They will also have the same special enrollment right at the end of continuation coverage if they continue coverage for the maximum time available to them.

Other Sources of Health Care Benefits

There may be other coverage options for you and your family. Under current law, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit under current law. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan does not accept late enrollees, if you request enrollment within 30 days.

For more information about health insurance options available under current law, visit **www.heathcare.gov**.

Notification of a Qualifying Event

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.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Teamsters Union 25 Health Services & Insurance Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Early Retiree Medical Program, the retired member is a qualified beneficiary with respect to the bankruptcy. The retired member's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

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
1-617-565-9600 or Toll free: 1-866-444-EBSA (3272)

Your Rights under HIPAA

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) is a Federal law that helps protect the continuity of health benefits coverage. HIPAA:

- limits exclusions for pre-existing medical conditions
- credits prior health coverage in the form of certificates
- prohibits discrimination in enrollment or in premiums charged, based on health-related factors
- guarantees renewability of health insurance coverage in the group insurance markets
- preserves the states' role in regulating health insurance

HIPAA helps individuals who lose coverage under one health plan to get coverage under another plan, in cases where that second plan may have "pre-existing condition" exclusions. HIPAA requires the "second plan" to reduce the length of its pre-existing exclusion period by the amount of time the individual was covered under the previous plan.

Since our TeamstersCare Plan does not have "pre-existing condition" limitations, participants who lose TeamstersCare eligibility and are looking for new coverage may encounter this problem for the first time. HIPAA entitles individuals to get a "certificate" from their previous plan that documents the length of their prior health coverage. This certificate can then be used to reduce whatever pre-existing condition exclusions might be imposed by the new plan. This HIPAA certification requirement applies only when you or your dependent(s) lose eligibility for TeamstersCare health benefits.

For members who lose eligibility, TeamstersCare will issue a certificate—*reflecting the single most recent period of continuous coverage*—under the following circumstances:

automatically

- when certification is required under HIPAA
- when an individual who is losing eligibility under the Plan is not entitled to COBRA
- when an individual has been covered by COBRA, but then COBRA coverage ends—this is true even when the individual may have previously received a certificate verifying earlier, pre-COBRA coverage under TeamstersCare

upon request

- before losing coverage or within 24 months of losing coverage

If you need such a certificate, please call Charlestown Member Services (see page 56 for contact information).

Privacy & Notice of TeamstersCare Privacy Policies

Teamsters Union 25 Health Services & Insurance Plan (TeamstersCare) is required by law to maintain the confidentiality and 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. The Trustees have amended the Plan to protect your PHI as required by federal law. PHI is information which:

- ***identifies you**, and*
- *relates to your past, present or future **physical or mental health or condition**, the **providing of health care** to you, or the **payment** for that care.*

How TeamstersCare May Use or Disclose Your Protected Health Information

TeamstersCare is legally obligated to inform you about when and under what circumstances it needs your authorization to use PHI and when or under what circumstances it does not need your authorization to use PHI. TeamstersCare does not need your authorization to use and disclose your protected health information for the purposes in the following categories:

1. 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.

2. Payment. We may use or disclose your PHI to determine eligibility for plan benefits, 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.

3. Health Care Operations. We may use and disclose your PHI 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. We are prohibited from disclosing your genetic information for any of these purposes.

4. 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.

5. 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.

6. 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 health care providers or the health care system.

7. 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.

8. 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.

9. Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI for the duties of a coroner, medical examiner, or funeral director to identify a deceased person, to determine the cause of death, or to perform other authorized duties.

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

11. 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.

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

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

14. Workers' Compensation. We may disclose your PHI to the extent necessary to comply with workers' compensation laws or similar laws.

15. 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.

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 your PHI without your authorization falls within one of these categories.

When TeamstersCare May Not Use or Disclose Your Protected Health Information

Except as permitted in this Notice of Privacy Practices, we will not use or disclose your PHI without your written authorization. Certain types of uses and disclosures of your PHI require an authorization, such as most uses or 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

1. Right to Inspect and Copy. You have the right to inspect and copy your PHI 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.

2. 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's labor costs in responding to your request for the copy.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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. 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 202-690-7000.

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

The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) puts the decisions affecting length of hospital stays after childbirth under the control 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
- prostheses, and
- treatment of physical complications from the mastectomy, including lymphedema

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, and mental health & substance abuse benefits.

It's extremely important to understand this concept called "Coordination of Benefits" (commonly referred to as 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 that your expenses are properly paid, but we also need to ensure that the total payments you're eligible to receive, from all of your benefits combined, do not exceed 100% of the charges you're billed. By "coordinating" our own Early Retiree Medical Program with other health coverage, 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. In order to provide a consistent method of deciding which plan pays first, and prevent the covered individual from being caught in the middle of a dispute between two plans, 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 Early Retiree Medical Program 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 pays first. The "secondary" 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 and a plan that covers you as a retired employee, the active plan is primary
- a TeamstersCare Retiree Program, 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 provision is secondary
- Medicare, then TeamstersCare 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: John Doe's spouse has primary coverage through 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,

John's spouse must obtain a referral from her Primary Care Provider in order to qualify for TeamstersCare secondary medical coverage.

Important Note: TeamstersCare will communicate with all benefit vendors, as appropriate, with respect to 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/Copays

Coordination of benefits does not apply to TeamsterShare Payments (copays) 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 who 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.

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 comes earlier in the calendar year.

Coordinating Coverage for Step-Children

If you remarry and add a spouse and step-child(ren) to the Plan, coverage for the child(ren) is coordinated in the following manner:

- If your spouse is divorced and the divorce decree specifies which parent is responsible for health care coverage, then this parent's coverage is prime. A copy of the divorce decree is required.
- If there is no divorce decree or the divorce decree does not state which party is responsible, then the custodial parent is prime. Documentation naming the custodial parent is required.

- If the parents have shared custody, then the "birthday rule" applies (using the birthdates of the natural parents).

Coordinating Coverage with Medicare

If you or your dependent becomes eligible for Medicare due to disability, then TeamstersCare is secondary to Medicare Part A and Part B.

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

Enrollment for Medicare Part B is not the same as for Part A. The two plans differ in a number of important ways. Part A covers hospital expenses, while Part B covers other medical expenses. In addition, you generally pay no premiums for Part A coverage, whereas you are required to pay a monthly premium for Part B coverage. If you need more information, call the Social Security Administration directly.

Important Note: If you and/or your spouse are eligible, you must enroll in Medicare Part B coverage. If you enroll, then Medicare will be primary. If you submit proof of Medicare Part B eligibility, TeamstersCare will reimburse you for the monthly Part B premiums. Reimbursement will begin the first month we receive a copy of your proof of coverage.

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 TeamstersCare Member Services (see page 56 for contact information).

Third Party Liability

In certain instances, a "third party" may be responsible for the cost of treating a covered 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 cover you for healthcare 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 under 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 pursue payment of the covered expenses directly from you, 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 or her guardian or estate) has, may have, or for which the member (and/or his or 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 under your motor vehicle insurance due to driving under the influence, or for any other reason attributable to your conduct, 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.

Your Rights as a Plan Member Under ERISA

At a number of places in this SPD, 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)—and accompanying medical option descriptions of benefits.

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 can 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 SPD and the documents governing the Plan for the rules that apply to your COBRA continuation coverage rights (see page 29 for details on Continuing Your Health Care Coverage Under COBRA).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that, in cases where you have become ineligible for TeamstersCare benefits, you are entitled to receive a "certificate" verifying your previous coverage under the TeamstersCare Plan. This verification

can then be used to reduce whatever pre-existing condition exclusions might be imposed by any new coverage you obtain.

Without such evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage (see page 33 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 person you've sued 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 person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

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.

Information About Teamsters Union 25 HS&IP

Plan Administrator/Named Fiduciary

The Teamsters Union 25 Health Services & Insurance Plan is a collectively bargained 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
Telephone: 617-241-9220

The Board of Trustees

Designated by Teamsters Union Local 25:

Sean M. O'Brien, Co-Chair
President/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
YRCW Worldwide
10990 Roe Avenue
Overland Park, KS 66211

Michael Rico
UPS East Region
643 West 43rd St
New York, NY 10036

Jason Paradis
Stop & Shop
P.O. Box 712
Wrentham, MA 02093

Michael Shaughnessy
Shaughnessy & Ahern Co.
346 D Street
Boston, MA 02127

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

Covered Plan participants contribute to the plan according to a schedule determined by age and date of retirement (see page 13 for more details).

Benefit Payment

TeamstersCare Early Retiree Medical Program benefit payments are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and Trust Agreement. TeamstersCare pharmacy, dental, hearing and vision benefits payments are provided from Plan assets and are not guaranteed under a policy of insurance. Medical benefits are provided through insurance. Plan assets are held in a trust fund for the purpose of providing benefits to covered participants and paying reasonable administrative expenses. The Plan Trustees may not amend or modify the Plan to reduce any benefits that have previously been approved for payment, as long as funds are available to pay these benefits.

Eligibility for Benefits

See information beginning on page 6 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, mutual funds 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
Telephone: 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 express 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. Generally, you must file the claim within 12 months of the date you received the service that the claim covers.

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 SPD and refer to the following chart for instructions and filing information. If you have questions or require further information, please call Charlestown Member Services (see page 56 for contact information).

Procedure for Filing Claims		
Vendor	**Contact Information**	**Notes**
HMO Blue New England	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131 1-800-241-0803	Providers file claims directly to Blue Cross. Member claims must be submitted within 12 months from the date of service.

Blue Care Elect Preferred (Out of Area Option)	Blue Cross Blue Shield of MA P.O. Box 9131 North Quincy, MA 02171-9131 1-800-241-0803	Providers file claims directly to Blue Cross. Member claims must be submitted within 24 months from the date of service.
Express Scripts/Medco	Express Scripts PO Box 2872 Clinton, IA 52733-2872 1-877-543-7097	You're required to submit a prescription drug claim if you fill a prescription without providing the information on your ID card, or if you use a non-network pharmacy. Claims must be submitted within 12 months of the date of service, and a claim form and itemized receipt are required.

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.

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 Trustees' 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 you cannot speak English, contact TeamstersCare for help—or have someone do this for you.

The SPD is designed to make your benefits as clear to you as possible. However, nothing written in the SPD 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.bluecrossma.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.bluecrossma.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 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**

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**

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