RETIREE PRESCRIPTION DRUG PROGRAM
&
RETIREE CLINICAL SERVICES AND VISION PROGRAM
SUMMARY PLAN DESCRIPTION
(For retirees and spouses age 65 and Over)

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

November 2020

A Letter from the Board of Trustees

Dear TeamstersCare Retiree:

As a retiree, age 65 or older, you and your spouse, depending on your age and years of credited service at retirement, may be eligible to elect coverage in the **TeamstersCare Retiree Prescription Drug Program** or the **TeamstersCare Retiree Clinical Services and Vision Program.**

The Retiree Prescription Drug Program benefits include outstanding pharmacy coverage with walk-in service through the TeamstersCare pharmacies in Charlestown and Stoughton MA, mail-order service through Express Scripts, and discounted costs at Express Scripts retail network pharmacies. In addition, you have access to TeamstersCare dental care at our Charlestown, Stoughton and Chelmsford facilities, hearing care at our Charlestown facility, clinical services such as our in-house vaccine clinics, and vision care through Davis Vision. TeamstersCare provides these services for a reasonable TeamsterShare Payment or, in some cases, no cost at all.

The **TeamstersCare Retiree Clinical Services and Vision Program** provides the benefits listed above, except for prescription drug coverage.

This Summary Plan Description (SPD) is a document designed to communicate, in understandable language, the basic details of the TeamstersCare Retiree Prescription Drug Program and the TeamstersCare Retiree Clinical Services and Vision Program. TeamstersCare administers the Programs 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. You should also make certain 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, visit us in person at any of our facilities, check our website at **www.teamsterscare.com**, or contact TeamstersCare Member Services at: local: 617-241-9220, ext 2, toll free in MA: 800-442-9939, ext 2; toll free outside MA: 800-225-6135, ext 2. **We're here for you…..Teamsters helping Teamsters!**

Board of Trustees

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Introduction

TeamstersCare provides two outstanding benefit programs for retirees and/or spouses age 65 and older as follows:

The **TeamstersCare Retiree Prescription Drug Program** provides prescription medications, TeamstersCare dental coverage, hearing care, clinical services such as our vaccine clinics, and routine vision services from TeamstersCare in-house professionals or from in-network TeamstersCare providers. For specific benefit details, refer to information beginning on page 14 of this Summary Plan Description (SPD).

The **TeamstersCare Retiree Clinical Services and Vision Program** provides TeamstersCare dental coverage, hearing care, clinical services such as our vaccine clinics, and routine vision services from TeamstersCare in-house professionals or from in-network TeamstersCare providers. For specific benefit details, refer to information beginning on page 19 of this Summary Plan Description (SPD).

Important Note*:** Eligible retirees, spouses, and dependents ***under age 65 may elect coverage in the TeamstersCare Early Retiree Medical Program. This Program is different from the TeamstersCare Retiree Prescription Drug Program and the TeamstersCare Retiree Clinical Services and Vision Program and is described in a separate Summary Plan Description. For details of the Early Retiree Medical Program—or for a copy of the Early Retiree Medical Program SPD—call TeamstersCare Member Services.

TeamstersCare Prescription Drug Program
Retiree Clinical Services and Vision Program

Eligibility

As a TeamstersCare retiree, provided you meet the appropriate eligibility requirements, you may elect coverage in one of the following TeamstersCare **Over age 65** Retiree Programs:

- the Retiree Prescription Drug Program *or*
- the Retiree Clinical Services and Vision Program

Although benefits under the two Programs are different, the eligibility requirements are the same. Most often, when an active member retires—while still under age 65—he or she first joins the Early Retiree Medical Program. Once a retiree in the Early Retiree Medical Program reaches age 65, coverage in the Early Retiree Medical Program ends. The retiree automatically becomes eligible for the TeamstersCare Retiree Prescription Drug Program or the Retiree Clinical Services and Vision Program on the first day of the month of the retiree's 65th birthday. The same Program options may apply when your spouse turns age 65.

If a retiree enrolled in the TeamstersCare Early Retiree Medical Program turns age 65 and decides not to enroll in either the TeamstersCare Retiree Prescription Drug Program or the TeamstersCare Retiree Clinical Services and Vision Program, eligible dependents may continue coverage in the TeamstersCare Early Retiree Medical Program. Please note that once a retiree drops retiree coverage, that retiree may not enroll in an Over-65 Program in the future, even if their spouse becomes eligible and enrolls.

Eligibility for the TeamstersCare Retiree Programs depends on four factors, all related to the date of the last day you were covered by the Active TeamstersCare Medical Program.

Eligibility depends on:

❶ your age, as of that date, and

❷ the years of credited service you have accumulated, as of that date.

Also, as of that date:

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

Credited Service

In determining eligibility, credited service means:

- your years of pension credit under the New England Teamsters & Trucking Industry Pension Fund or Central States Pension Fund (for carhaulers), 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

You're eligible for TeamstersCare retiree benefits 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 under the Active TeamstersCare Medical Program

In this case, you become immediately eligible for TeamstersCare retiree benefits.

Enrollment

You can join the TeamstersCare Retiree Prescription Drug Program or the TeamstersCare Retiree Clinical Services & Vision Program as of the first day of the month of your 65th birthday, or as of the last day of your active coverage, provided you are age 65 or older and have met all the eligibility requirements described above.

***Important Note*:** If you intend to join a TeamstersCare Over age 65 Retiree Program (whether immediately or on a deferred basis), you must notify TeamstersCare Member Services within 30 days of the date you first become eligible. If you do not timely notify Member Services, you will not be eligible to enroll at a later date.

Special Enrollment Under HIPAA – Postponing or Deferring Coverage

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 spouse becomes eligible for TeamstersCare retiree benefits but decline coverage at that time because you have other group health coverage, this is called deferring coverage. You may reapply for the TeamstersCare retiree benefits if you subsequently lose that other coverage. If you have deferred coverage, you and your qualified dependents may enroll in a TeamstersCare Retiree Program under the following circumstances:

- Loss of Group Coverage: If you lose access to your group health coverage because it is no longer available to you (not because you failed to make timely payments or as a result of a fraudulent claim, etc.) and provide TeamstersCare with proof of loss within 31 days, you may enroll in a Retiree Program as of the date your coverage ended.

Or

- Annual Open Enrollment: Deferred retirees have a one-time option to discontinue other group health coverage and enroll in a TeamstersCare Retiree Program for January 1st. Retirees who elect this option may not defer again in the future.

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 group health plan (not a government sponsored plan such as Medicare or Veterans Affairs) or you purchase COBRA continuation coverage at the time TeamstersCare first offers you retiree coverage, and
- You provide written notification ("deferral") and proof of your other group coverage to TeamstersCare at such time that this other coverage is the reason you are declining enrollment at that time.

And then,

- You become ineligible for your other group health coverage, or
- Your TeamstersCare COBRA coverage is exhausted, or
- You request enrollment in a TeamstersCare Retiree Program at Annual Open Enrollment.

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 loss of other health coverage.

Coverage for Spouse

Coverage for a spouse under the TeamstersCare Retiree Prescription Drug Program or the TeamstersCare Retiree Clinical Services and Vision Program begins on the first day of the month in which the spouse reaches age 65.

If you marry while you're covered under a TeamstersCare Retiree Program, you may enroll your spouse (age 65 or older), provided you request enrollment within 31 days after your marriage. You must also provide a copy of your marriage certificate at the time you request enrollment of your new spouse.

Coverage after Legal Separation/Divorce

In the event of divorce or legal separation, a court may order you to provide coverage for your former spouse. 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 TeamstersCare Member Services with the effective date of the divorce and documentation of the court order within 31 days of your divorce becoming final.

If your ex-spouse is covered and subsequently remarries, your ex-spouse is no longer an eligible dependent as of the date of marriage. ***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 coverage under the Teamsters Union 25 Health Services & Insurance Plan. Under the Plan you cannot cover a current spouse and an ex-spouse at the same time.

If your divorce agreement does not require you 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 24 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.

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

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 join the Early Retiree Medical Program or an Over age 65 Retiree Program, the member is considered to have retired as of the last day of eligibility under the Active Program. In this case, the member's spouse and/or dependent children may be eligible to enroll in either the Early Retiree Medical Program or, if your spouse is over age 65, the TeamstersCare Retiree Prescription Drug Program or the Retiree Clinical Services & Vision Program.

No Coverage for Dependents Under Age 65

The TeamstersCare Retiree Prescription Drug Program and the TeamstersCare Retiree Clinical Services & Vision Programs do not provide coverage to spouses under age 65 or to dependent children. Benefits may be available through the TeamstersCare Early Retiree Medical Program.

When Eligibility Ends

Retiree Eligibility

As the retiree, your eligibility for the TeamstersCare Over age 65 Retiree Programs ends on the earliest of the following:

- 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, as TeamstersCare follows the same contribution limitations as the New England Teamsters & Trucking Industry Pension Fund
- the date you voluntarily discontinue coverage
- when the deadline for requesting un-deferred enrollment has passed, i.e. beyond 31 days after losing coverage under another group plan
- the date the Program terminates

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

Your spouse's (or ex-spouse's) eligibility for the TeamstersCare Over age 65 Retiree Programs ends on the earliest of the following:

- 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, as TeamstersCare follows the same contribution limitations as the New England Teamsters &Trucking Industry Pension Fund
- when the deadline for requesting undeferred enrollment has passed, i.e. beyond 31 days after losing coverage in another group plan
- the date the spouse voluntarily discontinues coverage in the plan
- the date the retiree remarries and enrolls a new spouse, unless coverage for the new spouse is waived
- the date the ex-spouse or widow(er) remarries
- the date the Program terminates

Your Share of the Costs

Currently, TeamstersCare subsidizes a significant portion of the cost of the Retiree Prescription Drug Program for each retiree and spouse. Your monthly contribution amount for the Over age 65 TeamstersCare Retiree Programs is determined annually by the Board of Trustees. ***Your contribution is the same amount per month, whether you***

cover yourself alone or both yourself and your spouse, as long as you are both over age 65.

Because prescription drug and health care costs continue to rise, retiree contributions for the Retiree Programs will almost certainly increase each year for the foreseeable future. When retiree monthly contribution amounts change, TeamstersCare advises you by mail. For information on current retiree contribution rates, call TeamstersCare Member Services.

***Important Note*:** In most instances, if you collect a pension from the New England Teamsters & Trucking Industry Pension Fund, you must authorize automatic deduction of your TeamstersCare monthly contribution amount.

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 spouse. This includes, but is not limited to, the following:

- a change in your name or address, or the name or address of an eligible dependent
- marriage, divorce or legal separation, or the mandate of a court order
- death of an eligible participant
- any change in your own or your dependent's employment-related healthcare coverage

***Important Note*:** If you have a change in family status you—or someone acting on your behalf—must notify TeamstersCare Member Services by telephone or in writing within 31 days of the change (see page 49 for contact information). TeamstersCare may require that you submit certain changes in writing, or proof of your change in family status, at the time you notify us of the change.

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 retiree's suspension could result from:

- not responding to a request for information
- not submitting an *Enrollment Form* when TeamstersCare requires you to do so
- enrolling an ineligible dependent
- not repaying a lien after you receive a monetary award
- not repaying the Plan after you have received proceeds from a third party

- 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 monthly contribution amount

TeamstersCare Retiree Prescription Drug Program Benefits

You and your spouse (age 65 and over) have access to a variety of important healthcare services provided directly by TeamstersCare through its own dedicated staff and facilities or through in-network providers.

These services include:

- Prescription drugs
- TeamstersCare dental care
- TeamstersCare hearing care
- Davis Vision routine vision care
- TeamstersCare Flu & other Vaccine Clinic coverage

Pharmacy Benefits

As a retiree in the TeamstersCare Retiree Prescription Drug Program, you and your spouse (age 65 and over) have the following options available when you need pharmacy 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 eligible spouse for a $5 (generic)/$15 (brand name) TeamsterShare Payment per prescription. The TeamstersCare in-house pharmacies offer you an easy, cost-effective way to fill prescriptions, including those you use on an ongoing basis, such as heart or blood pressure medication and diabetic supplies.

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

- take your prescription to the TeamstersCare Pharmacy in Charlestown or Stoughton
- have your doctor call in the prescription to the TeamstersCare Pharmacy
- have your doctor e-prescribe or 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

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

1. **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.

2. **Go online using Refill Netmanager** … available to refill your prescriptions at either of our TeamstersCare Pharmacies. Simply go to www.teamsterscare.com, and click on Benefit Providers/Pharmacy, follow the prompts to the TeamstersCare Pharmacies until you locate the **Refill Netmanager** system where you can complete the Online Prescription Refill Form. Be sure to have your old prescription available, as you will need the 6 digit refill number.
3. **Call ahead using Telemanager** … an automated telephone system, available to refill a prescription at the Stoughton (781-297-9764) or Charlestown (617-241-9024) TeamstersCare 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.

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

Charlestown hours: Walk-in Service

- *Monday through Thursday* *8:00am to 6:00pm*
- *Friday and Saturday* *8:00am to 4:00pm*
- *Local phone: 617-241-9024 Toll free: 800-235-0760 Fax: 617-241-5025*

Stoughton hours: Walk-in Service

- *Monday, Tuesday, Thursday, Friday & Saturday* *8:00am to 4:00pm*
- *Wednesday* *8:00am to 6:00pm*
- *Local phone: 781-297- 9764* *Fax: 781-297-9370*

Call ahead to the TeamstersCare Pharmacy 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 is a part of the Express Scripts family of pharmacies.

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

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

Option #3: Retail Pharmacy Service:

You can use a retail pharmacy that participates in our Express Scripts retail network; however, **you will pay 100% of a pre-discounted cost.** *Please note that Walmart, Sam's Club and Walgreens are not in the Express Scripts network.*

Specialty Medication Program:

TeamstersCare has a **dedicated program for specialty medications**. These are complex medications that treat serious health conditions and may require intensive monitoring. Many of these medications also require Prior Authorization.

Some of these "specialty medications" are available at TeamstersCare Pharmacies for pick-up, otherwise you must use 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.

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, so be sure to ask the pharmacist.

As a way of holding down Plan costs—and your costs as well—TeamstersCare Pharmacies and the Express Scripts/Medco mail order pharmacy will fill prescriptions for brand named 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 an Express Scripts network pharmacy, or to some other non-network retail pharmacy. In either case, you'll need to pay 100% of the pre-discounted 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. When you fill the prescription for the first time, you may choose to receive up to a 30-day supply at no cost to you. If the medication works for you, you may fill the balance of the prescription, up to a 60-day supply, for a $5 (generic)/$15 (brand name) TeamsterShare Payment. If the medication doesn't work for you, and your doctor switches you to another dosage or prescribes a new medication, you will have saved the TeamsterShare Payment for the initial prescription.

Prescription Drug Costs Chart

<table>
<tr><th>If your prescription is written for:</th><th>You Pay:</th><th>The Plan Pays:</th></tr>
<tr><td colspan="3">At the Charlestown and Stoughton TeamstersCare Pharmacies or at Express-Scripts mail-order (up to a 90-day supply)</td></tr>
<tr><td>generic medication</td><td>$5</td><td rowspan="2">100% of the remaining cost</td></tr>
<tr><td>brand name medication—and no generic is available</td><td>$15</td></tr>
<tr><td>brand name medication—and generic is available</td><td colspan="2">This option not available at In-house TeamstersCare Pharmacies or through Express-Scripts mail-order</td></tr>
</table>

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
- Prozac weekly
- medication for cosmetic use
- experimental medications
- experimental use of approved medications
- medication covered by Workers' Compensation, in cases where your illness or injury is work-related
- prescriptions older than one year from the date originally prescribed
- immunization agents, certain vaccines, blood or blood products
- illegal drugs
- any of the following, unless dispensed from our TeamstersCare Charlestown or Stoughton Pharmacies or Accredo Specialty Pharmacy
  - injectables
  - tretinoin (RetinA)
  - growth hormone
  - diabetic supplies (test strips, lancets, etc.)

For a complete list of medications not covered, call a TeamstersCare Pharmacy (See page 49 for contact information) or visit **www.teamsterscare.com.**

Prescription Medication Limitations

TeamstersCare reserves the right to limit covered therapies and deny coverage for specific medications. Examples of prescription medications with limitations include:

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

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

Medications Requiring Prior Authorization

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

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

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

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.

TeamstersCare Prescription Drug Program Benefits
Retiree Clinical Services and Vision Program Benefits

You and your spouse (age 65 and over) have access to a variety of important services provided directly by TeamstersCare through its own dedicated staff and facilities or through a network of specialized providers.

These services include:

- TeamstersCare dental care
- TeamstersCare hearing care
- Davis Vision routine vision care
- Clinical services such as TeamstersCare vaccine clinics

Important Note: The TeamstersCare Retiree Clinical Services and Vision Program does not include prescription drug coverage.

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 licensed and experienced dentists, hygienists, and dental assistants.

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 8:00am, some evening appointments until 8:00pm
- Friday and Saturday—8:00am to 4:00pm

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

Charlestown

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

Chelmsford

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

Stoughton

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

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

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

Hearing Care Benefits

Once each year, you and spouse (age 65 and over) can have comprehensive hearing testing done at the Charlestown Audiology Office at no cost to you.

Our TeamstersCare staff audiologist can provide the following services:

- ear examination
- diagnostic hearing evaluation
- middle ear analysis
- recommendation and referral to a local vendor for the purchase of a hearing aid at a discounted price

Hearing Aids

In the Over age 65 TeamstersCare Programs, hearing aids are not a covered benefit. However, you and your spouse (age 65 and over) may obtain significant discounts on the purchase of medically necessary hearing aids. The TeamstersCare audiologist will assist you through the process.

Hearing Aid Service & Repair

If you received your hearing aid from an outside vendor, you should return to that vendor for service or repair of the hearing aid. In this case, hearing aid repair is not a covered benefit.

If you received your hearing aid through the TeamstersCare Audiology Office during a period when you were eligible for the TeamstersCare hearing aid benefit (for example, while you were a member of the Active Medical Program), then TeamstersCare will cover the repair of your hearing aid for up to five years after the date you received it—provided you are enrolled in a TeamstersCare Program at the time of the repair.

To schedule an appointment for a hearing evaluation, call the TeamstersCare Charlestown appointment desk at 617-241-9220 ext 1.

Vision Benefits

TeamstersCare has contracted with Davis Vision to provide benefits for you and your eligible spouse to 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 TeamstersCare Member Services.

Your TeamstersCare Vision Benefit

Participating Davis Vision professionals can provide you and your eligible spouse with the following services and supplies once every 24 months:

- routine eye examinations, covered at 100%
- two pairs of prescription eyeglasses from the Davis Vision Collection, covered at 100% unless optional lens types and coatings are selected, or
- in lieu of eyeglasses, one dispense of 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 your 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 breakage warranty. You and your eligible spouse can select:

- up to two pairs of eyeglasses — frames from the Fashion, Designer and Premier levels of the Davis Vision collection are covered in full; many lens options are at no cost to you, but certain lens types and coatings are an additional charge, or
- for a $25 copay:
  - planned replacement disposable contact lenses from Davis Vision's collection, up to 2-4 boxes/multipacks based on manufacturer's packaging

    or
  - $150 allowance toward any toric or gas permeable contacts from the provider's supply

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

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 before you can select eyeglasses from the Plan. Also, once the contact lenses are fitted, you cannot exchange them for eyeglasses. 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 that is not covered by the Plan, TeamstersCare will pay for your eye exam, but you must pay all other costs.

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.**

Laser Vision Correction

Davis Vision provides you and your eligible spouse with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit **www.davisvision.com.** Aside from this discount, laser vision correction surgery is not a covered benefit.

Making an Appointment

To schedule an appointment, call a Davis Vision provider's office directly. When you call, the Davis Vision professionals will help determine whether you're eligible for an examination and eyeglasses under the Plan. You can find a Davis Vision provider by calling 1-800-283-9374 or by going to the Davis Vision website at **www.davisvision.com**. For more information about Davis Vision benefits, call TeamstersCare Member Services or visit our website at **www.teamsterscare.com**.

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

Administration

Continuing Health Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), the spouse of a retiree covered under a healthcare plan has the option to

continue coverage under the Plan for up to three years if coverage is lost as a result of any of the following qualifying events:

- divorce
- legal separation

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

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

Cost of Continued Coverage

Your spouse will be required to pay up to 102% of the full cost of coverage continued under COBRA as may be determined by TeamstersCare. 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 paying this first premium, subsequent payments must be made by the first of every month. However, each month, there is a 30-day grace period in which to pay the premium.

During a premium-payment "grace period":

- eligibility cannot be confirmed nor any claims processed until the premium has been paid, and
- if you are enrolled in the Retiree Prescription Drug Program, prescriptions cannot be filled at a TeamstersCare pharmacy or an Express Scripts 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 inform you ahead of time. For current coverage costs, contact Charlestown Member Services (see page 49 for contact information).

Period for Deciding about COBRA Coverage

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

- the date your spouse receives notice of 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 eligible dependent should take into account the special enrollment rights available under federal law. Your eligible dependent has 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.

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 or your spouse is responsible for this notification if eligibility would otherwise end because:

- you become divorced or legally separated

For these events, you or your spouse 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 TeamstersCare is not notified 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 TeamstersCare Over age 65 Retiree Program, the retired member is a qualified beneficiary with respect to the bankruptcy. The retired member's spouse or surviving spouse will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

Medicare Enrollment

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you.**

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:

- 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
- before losing coverage or within 24 months of losing coverage

If you need such a certificate, please call TeamstersCare Member Services (see page 49 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.

Coordination of Benefits
TeamstersCare Retiree Prescription Drug Program

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, such as prescription drug coverage.

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 TeamstersCare Prescription Drug coverage 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 TeamstersCare Retiree Prescription Drug 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."

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 TeamstersCare Pharmacies/Express Scripts

TeamstersCare Pharmacies are available only to members and spouses who have TeamstersCare as primary coverage. The same is true for the Express Scripts network. This means in cases where other coverage is primary, a person is not eligible to use TeamstersCare Pharmacies or their Express Scripts 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 TeamstersCare Member Services for coordination and reimbursement.

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 49 for contact information).

***Important Note*:** You may only participate in one Medicare Part D Plan. Therefore, while you and/or your spouse are covered by the TeamstersCare Retiree Prescription Drug Program, you may not enroll in another Medicare Part D Plan.

If you terminate coverage in the TeamstersCare Retiree Prescription Drug Program, you cannot enroll at later date unless you have deferred coverage. (See Special Enrollment Under HIPAA on page 9.) You may, however, elect to join the TeamstersCare Retiree Clinical Services and Vision Program within thirty days of terminating coverage in the TeamstersCare Retiree Prescription Drug Program.

Your Rights as a Plan Member Under ERISA

At a number of places in this Summary Plan Description, 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)

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 Administrative 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 and your spouse if you lose coverage under the Plan as a result of a qualifying event. You or your spouse 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 24 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 28 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
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 and Principal Officer
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

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

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

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

Designated by the Employers:

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

Michael Rico
UPS
643 West 43rd St – 6th floor
New York, NY 10036

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

John W. White
Freeman Expositions, LLC
275 Bodwell Street
Avon MA 02322

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 on a monthly basis. The amount is determined annually by the Board of Trustees.

Benefit Payment

TeamstersCare Over age 65 Retiree 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. 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 7 for detailed information on:

- benefit eligibility
- disqualification, ineligibility, denial, suspension, or loss 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 49 for contact information).

Procedure for Filing Claims		
Vendor	**Contact Information**	**Notes**
Express Scripts	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 Trustee's decision will include the following:

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

terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Board of Trustees Decision is Final and Binding

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

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

Final Notes

If you have questions about your benefits, or if you do not understand the Plan because 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: Administrative Office Member Services Office Dental Office Audiology Office Board of Trustees Employee Assistance Program (EAP)	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** **EAP Hotline: 1 (800) 851-8326**

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 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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