SUMMARY PLAN DESCRIPTION

of the

Plan of Benefits

of the

TEAMSTERS JOINT COUNCIL NO. 53 RETIREE HEALTH AND WELFARE FUND

August 2018

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INTRODUCTION

About This Booklet

To All Eligible Participants:

The Teamsters Joint Council No. 53 Retiree Health & Welfare Fund helps provide you and, in most cases, your spouse with medical, dental, vision and prescription drug coverage during your retirement years.

This booklet, which also serves as the Plan Document, describes the Plan as in effect on August 1, 2018. The terms and conditions of the Plan, as well as the particular benefits provided through the Plan, are subject to change and/or amendment from time to time at the discretion of the Plan's Retirement Committee. Should changes be implemented, you will be sent a "Statement of Material Modification" describing any such changes. Such statements are generally sent via first class mail to the participant's last known address on file with the Plan.

We encourage you to read this booklet carefully and share it with your spouse to ensure that you understand your rights under the Plan. When you are finished reading this booklet, file it with your important papers (along with any "Statements of Material Modification") so you can refer to it later.

Sincerely,

The Retirement Committee

GENERAL INFORMATION

1. **Plan Identification:**

Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
Employer Identification Number: 23-2530237
Plan Number: 501
Plan year: Fiscal year beginning July 1

2. **The Plan Sponsor is:**

Retirement Plan Committee of the
Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
3460 N. Delaware Avenue
Suite 310
Philadelphia, PA 19134
215-634-4567

3. **The members of the Retirement Plan Committee are:**

William Hamilton, Chairman	Howard W. Wells, Treasurer
Daniel Grace	Brian Reice
Patrick Connors	Jock Rowe
Michael Bonaduce	Robert "Rocky" Bryan, Jr.
Joseph Smith	Dennis Hower

The mailing address for each of the Retirement Committee members is:

Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
3460 N. Delaware Avenue
Suite 310
Philadelphia, PA 19134

4. **The Agent for Service of Legal Process is:**

Administrative Service Professionals, Inc.
2500 McClellan Ave, Suite 140
Pennsauken, NJ 08109

In addition, one or more of the Retirement Plan Committee members may be served with legal process.

5. **Service Providers** – The following provide the designated services to the Plan:

Legal Counsel:
Markowitz & Richman
Suite 2020
123 S. Broad Street
Philadelphia, PA 19107

Actuarial Consultant:
The McKeogh Company
Four Tower Bridge
Suite 225
W Conshohocken, PA 19428

Investment Consultant:
SEI Investments
One Freedom Drive
Oaks, PA 19456

Administrative Services:
Administrative Service
Professionals, Inc.
2500 McClellan Ave
Suite 140
Pennsauken, NJ 08109

Fund Custodian:
Wachovia Bank, N.A.
Retirement Services
123 S. Broad Street
Philadelphia, PA 19109

Hosp/Med/Surg Coverage:
Teamsters H&W Fund
2500 McClellan Ave, Suite 140
Pennsauken, NJ 08109

Dental Benefit Carrier:
United Concordia
1000 First Avenue, Suite 403
King of Prussia, PA 19406

Vision Benefit Carrier:
Vision Benefits of America
300 Weyman Plaza
Pittsburgh, PA 15236

Rx Drug Benefit Manager:
Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

6. **Financing** –

Benefits under the Plan are financed through Employer contributions and monthly premium copayments from eligible participants. The rate of Employer contributions and the amount of participant premium copayments are set from time to time by the Retirement Committee. As of August 1, 2018, the monthly participant premium copayments are as follows:

	Non-Medicare Eligible	**Medicare Eligible**
Retirees	$174.37 per month	$75.37 per month
Dependents	$290.61 per month	$125.62 per month

Benefits under the Plan are provided through the purchase of insurance contracts for the Plan's, dental and vision programs and through a participation agreement with the Teamsters Health & Welfare Fund of Philadelphia and Vicinity for coverage for those not yet eligible for Medicare coverage. The Medicare Supplement Program and the Prescription Drug Benefit Program are self-insured by the Plan.

ELIGIBILITY RULES

1. The Fund provides Health & Welfare benefits, as determined by the Committee, to all retirees who:

   a. have retired after January 1, 1987,
   b. are receiving a pension benefit from Teamsters Joint Council No. 53 Retirement Trust,
   c. have reached the age of fifty-five (55),
   d. have ten (10) years of service,
   e. were in employment covered by the Teamsters Joint Council No. 53 Retirement Trust within five (5) years prior to the date of their retirement, and
   f. whose last employer remains a contributing employer, except in cases of dissolution or merger, to both the Teamsters Joint Council No. 53 Retirement Trust and this Plan as of that individual's initial eligibility date under this Plan.

   A year of service is defined as employment with a Contributing Employer in which the employee works at least one thousand (1,000) hours.

2. If a retired participant covered by this Plan returns to employment, such person will not be eligible for coverage by the Fund upon future retirement unless such person has been employed for one (1) year after returning to such employment. Persons who are actively employed by Teamsters Joint Council No. 53 or any Local Union or other entity that contribute to this Fund on behalf of its employees, are not entitled to coverage under this Plan during such period of active employment even if they are receiving a pension benefit from Teamsters Joint Council No. 53 Retirement Trust.

3. Health & Welfare benefits determined by the Committee will provide coverage of lifetime duration for eligible Retirees and their surviving spouses provided that the Retiree was married to said spouse at the date of his or her retirement. Such coverage will also be provided to persons who qualify for and are receiving a disability pension for the Teamsters Joint Council No. 53 Retirement Plan, who incur such disability while in active employment covered by such Retirement Plan, and who have ten (10) years of service and have reached fifty (50) years of age. However, when a Retiree reaches social security retirement age, such coverage may be modified by the Committee to provide for and encompass the eligibility of a participant and/or beneficiary for Medicare coverage or such other or similar coverage provided by federal or state law. A retiree and his spouse shall have the right to waive entitlement to the benefits provided by this Plan upon execution of a wavier by the retiree and spouse; such waiver may be revoked provided proof of continued coverage is provided.

4. A spouse of an eligible retiree will lose coverage under the Plan upon divorce and will be afforded the opportunity to enroll in the Plan's Continuation of Coverage program (COBRA).

5. Should an eligible Retiree marry after his or her initial eligibility date, the spouse of such

retiree shall become eligible under the Plan as of the date of marriage and payment of the applicable premium copayment. Said spouse shall continue to be eligible under the plan until (a) non-payment of the required monthly premium copayment, (b) his or her death, or (c) death of the eligible Retiree, whichever shall first occur. In the event of loss of coverage by reason of the death of the eligible Retiree, said surviving spouse will be afforded the opportunity to enroll in the Plan's Continuation of Coverage program (COBRA).

6. A participant will lose coverage under the Plan thirty (30) days after non-payment of the monthly premium copayment set by the Retirement Committee or upon his or her death, whichever shall first occur.

CONTINUATION OF COVERAGE

If you should lose coverage under the Plan by reason of a “qualifying event” (as that term is defined under applicable Federal law and regulation), the following provisions shall apply to you:

COBRA CONTINUATION COVERAGE

In some cases, should you and/or your spouse become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights, under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your spouse if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The COBRA premium rates are formulated by the Fund's Actuary in accordance with formulas defined in the federal COBRA law.

A member has the right to extend his coverage if the coverage ends because you no longer meet the eligibility requirements due to the occurrence of a “qualifying event.”

Your spouse has the right to extend coverage if you die or no longer meet the eligibility requirements due to the occurrence of a “qualifying event,” or you are divorced or legally separated.

It is the responsibility of the person who will lose coverage to inform the Administrator of a divorce or legal separation. The Administrator must be notified, in writing, within sixty (60) days after one of these events occur. If the Administrator is not notified, then that person will not be able to elect to continue his or her other coverage.

Once the Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he or she has the right to choose continuation coverage. He or she then has at least sixty (60) days from the date he or she would lose coverage to let the Administrator know that he or she wants to continue coverage. If the Qualified Beneficiary did not choose it, the right to continue the group health coverage would then end. If he or she does choose it, he or she will be offered the right to continue the same coverage he or she was receiving the day before he or she lost coverage. Each Qualified Beneficiary can make a separate choice on whether to continue coverage. However, one person can make an effective choice to continue coverage for everybody. You can choose to continue only your core benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

Certificate of Former Coverage

If you or your spouse lose coverage under the Plan, you will receive a certificate of former coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may request another copy of the certificate within 24 months of losing coverage.

If coverage ended because you no longer meet the eligibility requirements, coverage may continue for up to 18 months. If coverage ended for any other reason, then coverage may be continued for up to thirty-six (36) months. These time periods may be shortened if:

a. The Fund no longer provides group health coverage for any employee;
b. You do not pay the required premium in a timely fashion;
c. You are later employed and are covered by another group health plan that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
d. You become eligible for Medicare; or
e. You are divorced, subsequently remarry and are covered under your new spouse's group health plan.

Special Rule for Multiple Qualifying Events

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18 month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse of a covered employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

Special Rule for Totally Disabled Qualified Beneficiaries

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who is determined to have been disabled (for Social Security purposes) at the time your work hours were reduced, or your employment ended, or any time during the first sixty (60) days of the 18 month period during which you are enrolled in the COBRA program. To qualify for this additional coverage, the individual must provide the Plan with notice, within sixty (60) days of the date of the determination and before the end of the 18-month coverage period, of Social Security's disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50 percent higher.

If you have any questions about this continuation coverage, please contact the Fund office.

PRIVACY PRACTICES

THESE PROVISIONS DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

What follows is a Notice of Privacy Practices of the Teamsters Joint Council 53 Retiree Health & Welfare Fund (the "Plan"). The Notice establishes the circumstances under which the Plan may share your protected health information with others in accordance with the Health Insurance Portability and Administrative Accountability Act of 1996 (HIPAA) Privacy Rules.

The Plan may use your protected health information ("PHI") for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

YOUR PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED IN THE FOLLOWING CIRCUMSTANCES AND FOR THE FOLLOWING PURPOSES:

To Make or Obtain Payment. The Plan may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Plan may use or disclose PHI for its own operations to facilitate the administration of the Plan and, as necessary, to provide coverage and services to all of the Plan's participants and beneficiaries. Health care operations includes activities such as:

a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guidelines and protocol development, case management and care condition.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and performance evaluations.
f. Accreditations, certification, licensing or credentialing activities.
g. Underwriting premium rating to related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analyses and formulary development.
j. Business management and general administrative activities of the Plan, including member services and resolution of internal grievances.

For example, the Plan may use your PHI to conduct case management quality improvement, disease management, utilization review, or engage in member service and grievance resolution activities.

For Treatment Alternatives. The Plan may use or disclose your PHI to tell you about or recommend possible treatment operations or alternatives that may be of interest to you.

For Distribution of Health Related Benefits and Services. The Plan may use or disclose your PHI to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Plan may disclose your PHI to the plan sponsor, the Retirement Committee of the Plan, for plan administrative functions performed by the Retirement Committee on behalf of the Plan. In addition, the Plan may provide summary health information to the Retirement Committee so that the Retirement Committee may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan may also disclose to the Retirement Committee information on whether you are participating in the Plan.

Where Required or Permitted by Law. The Plan may also use or disclose your PHI where required or permitted by law. In that regard, HIPAA generally permits health plans to use or disclose PHI for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research functions, such as related to military service or national security; or to comply with the Workers' Compensation laws.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Except as stated above, the Plan will not disclose your PHI other than with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your PHI that the Plan maintains:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. You have the right to require a limit on the Plan's disclosures of your PHI to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Plan's Privacy Officer (see Contact Person below).

Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing and mail it to the Plan's Privacy Officer (see Contact Person below). The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy your Protected Health Information. You have the right to inspect and copy your PHI with some limited exceptions. A request to inspect and copy records containing your PHI must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). If you request a copy of your PHI, the Plan may charge a reasonable fee for copying, assembling and postage, if applicable, associated with your request.

Right to Amend your Protected Health Information. You have the right to request an amendment to your PHI records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The Plan may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request may also be denied if your PHI records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend includes information you are not permitted to change, or if the Plan determines that records containing your PHI are accurate and complete.

Right to an Accounting. You have the right to obtain a list of disclosures of your PHI made by the Plan for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2004. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Copy of This Notice. You have a right to obtain and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Plan's Privacy Officer (see Contact Person below).

DUTIES OF THE PLAN

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to

the Plan and to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Plan has designated Maria Scheeler as its contact person ("Privacy Officer") for all issues regarding patient privacy and your privacy rights. You may contact this person as follows:

Maria Scheeler, Privacy Officer
Teamsters Joint Council 53 Retiree Health & Welfare Fund
P.O. Box 129
Collingswood, NJ 08108

EFFECTIVE DATE

This Notice was effective April 14, 2004, was revised effective July 1, 2008 and, as revised, remains in effect as of this printing.

If you have any questions regarding this Notice, please contact Maria Scheeler, Privacy Officer, Teamsters Joint Council 53 Retiree Health & Welfare Fund, P.O. 129, Collingswood, NJ 08108, 856-382-2410.

EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")

IMPORTANT INFORMATION REQUIRED BY ERISA

1. The Plan Year starts on July 1 and ends on June 30, and consists of an entire twelve (12) month period for the purposes of accounting and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

2. The Plan is maintained by more than ten Participation Agreements which are between the Plan and various employers (primarily Local Unions affiliated with the International Brotherhood of Teamsters and related entities).

3. The Plan is funded through employer contributions, the amount of which is specified in the Participation Agreements, and monthly premium copayments set by the Retirement Committee and paid by retired participants.

4. Benefits provided under the Plan, other than Medicare Supplemental benefits and Prescription drug benefits, are insured through the purchase of group insurance. Medicare Supplement benefits and prescription drug benefits are self-insured and are paid directly from the corpus of the Trust Fund. The Retirement Committee retains the right to amend the Plan of Benefits set forth in this booklet to the fullest extent provided by law.

5. The Participation Agreements referenced above may be reviewed at the Fund office.

6. Upon written request, the Administrator will furnish you with information as to whether a particular employer participates in the Plan and, if so, his address.

7. This Plan provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, and Prescription Drug Benefits. Please refer to the Table of Contents and the Summary of Benefits Schedule for more information concerning the benefits provided under this Plan.

IMPORTANT INFORMATION REQUIRED BY ERISA

As a participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, provided that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, Participation Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, insurance contracts, if any, Participation Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subjected to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. **The Fund's Plan does not contain any exclusions for preexisting conditions.**

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, your have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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 may file suit in a Federal court. In such a case, 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 have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may 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 fees. If you lose, the court may order you to pay these costs and fees. For example: If it finds your claim is frivolous.

Assistance 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 nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN CHANGE OR TERMINATION

The Retirement Committee reserves the right to change or discontinue: (a) the types and amounts of benefits under the Plan; and (b) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active or disabled participants:

- are not guaranteed;
- may be changed or discontinued by the Retirement Committee;
- are subject to the rules and regulations adopted by the Retirement Committee;
- are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- are subject to the provisions of any group insurance policies purchased by the Retirement Committee.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

BENEFITS PROVIDED UNDER THE PLAN

The type of medical benefits under which you enjoy coverage vary with your age, that is, whether you are over or under the age of 65. Those under the age of 65 are covered under an insured PPO program ("Personal Choice") administered by Independence Blue Cross. Those participants over age 64 are covered under a Medicare Supplement program that the Plan self-insures.

Coverage for dental, vision and prescription drug benefits is the same, regardless of the participant's age.

You are covered under:

If you are eligible and are:	Personal Choice PPO Plan	Medicare Supplement Plan*	Dental Program (United Concordia)	Prescription Drug Program (Express Scripts)	Vision Program (Vision Benefits of America)
Under Age 65	**√**		**√**	**√**	**√**
Age 65 or older		**√**	**√**	**√**	**√**

* You must be enrolled in Medicare Parts A and B to be eligible for this supplemental benefit

In order to be considered timely filed, claims must be received by the Contract Administrator no later than June 30th of the third plan year following the plan year in which the claim was incurred.

Detailed descriptions of the coverages provided under these programs are more fully described in the pages appended to this document.

In addition, and in accordance with Federal law:

- coverage under the Plan includes coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the PPO Claims Administrator.

COORDINATION/SUBROGATION OF BENEFITS

Under no circumstances will the Fund pay any benefits under this Plan as the Primary Plan when a Spouse has elected to make this Plan the Primary Plan by waiving any other insurance offered to the Spouse by virtue of his or her employment. This is true whether or not the other insurance is offered with or without charge and whether or not the waiver is made with or without consideration. Notwithstanding the foregoing, a Spouse is not required to purchase coverage through his or her Employer if the Spouse is required to pay the entire premium for the coverage. The Retirement Committee may implement rules and regulations regarding the level of co-payment for employer-provided insurance required of a Spouse under this provision.

The following rule applies to any situation in which the Plan makes any full or partial payment to or on behalf of a participant who subsequently recovers from any other source additional payments or benefits in any way related to the accident, illness, or treatment for which the Fund made full or partial payment:

> Upon any such subsequent recovery by or on behalf of a participant, from any person or persons, party or parties, insurance company, firm, corporation, or government agency, whether by suit, judgment, settlement, compromise, or otherwise, the Plan, with or without the signing of a subrogation agreement, shall be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the participant. The Plan shall be first reimbursed fully by or on behalf of such participant to the extent of benefits paid from the monies paid by any person or persons, party or parties, insurance company, firm, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the participant. The participant shall hold, as a fiduciary in constructive trust for the benefit of the Plan, any monies so recovered that are subject to the Plan's subrogation/reimbursement lien or these provisions.
>
> All participants are obligated to cooperate with the Plan in its efforts to enforce its subrogation rights and to refrain from any actions which interfere with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation agreement in a form prescribed by the Plan. The Plan shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a participant refuses to sign a subrogation agreement, refuses to reimburse the Plan in accordance with the Plan's subrogation rights, or takes any other action inconsistent with the Plan's subrogation rights. In such situations, the Plan's options shall include, without limitation, the right in appropriate cases to deny benefits to an individual who refuses to sign a subrogation agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and/or to offset wrongfully withheld sums against future benefit payments otherwise owed the individual who retains such sums. The Plan may pay counsel fees in an amount not to exceed 20% in order to protect the Plan's subrogation interests.

CLAIMS APPEAL PROCEDURES

If you are covered under the pre-age 65 medical program (currently the Blue Cross Personal Choice program), appeals from claims denials are subject to and governed exclusively by the procedures set forth in the Member Handbook issued to you by Blue Cross.

Appeals relating to denials for dental and vision related claims are subject to and governed exclusively by the review procedures set forth in the group insurance booklets. Refer to those materials for a more full explanation of those procedures.

If the claim denial you wish to appeal falls under either the Medicare Supplement program or the Prescription Drug program, the following procedures apply with respect to the claim review/appeal of such a claim:

a. **Statement of Intent**. The Retirement Committee intends to establish and to maintain reasonable claim procedures as required by law.

b. **Authorized Representative**. A Claimant for benefits under this Plan may appoint an authorized representative to act on the Claimant's behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Plan as the authorized representative of a Claimant should contact the Fund office.

c. **Filing of Claims**. Any participant or former participant under the Plan ("Claimant"), may file a written claim for benefits with the Retirement Committee through the Fund office.

d. **Notification on Denial of Claim**. In the event of an adverse benefit determination, the Plan (or Express Scripts, “the PBM,” in the case of prescription drug claims) will send the Claimant a written notification containing specific reasons for the adverse benefit determination. The written notification will contain specific reference to pertinent Plan provisions on which the adverse benefit determination is based. In addition, the written notification will contain a description of any additional material or information necessary for the Claimant to perfect the claim, as well as an explanation of why such material or information is necessary. Furthermore, the notification shall provide appropriate information as to the steps to be taken if the Claimant wishes to seek review of the adverse benefit determination.

e. **Time Frames**. The following time frames will apply to benefit determinations by the Plan:

   (1) **Urgent Care Claims**. In the case of a claim involving urgent care, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant has failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan or the PBM shall notify the

Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph d of this section. The Plan or the PBM shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

(2) **Concurrent Care Decision**. If the Plan or the PBM has approved an ongoing course of treatment to be provided over a period of time or a number of treatments --

(a) Any reduction or termination by the Plan or the PBM of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan or the PBM shall notify the Claimant in accordance with Paragraph e of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.

(b) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Plan or the PBM shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, 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. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Paragraph e of this section, and appeal shall be governed by Paragraph g(5)(a), (b) or (c) of this section, as appropriate.

(3) **Pre-Service Claims**. In the case of a pre-service claim, the Plan or the PBM shall notify the Claimant of the Plan's 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 by the Plan or the PBM. This period may be extended one time by the Plan or the PBM for up to 15 days, provided the Plan or the PBM both determine that such an extension is necessary due to matters beyond the control of the Plan or the PBM, and notifies the Claimant 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 or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant

shall be afforded at least 45 days from receipt of the notice within which to provide this specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph e of this section.

(4) **Post-Service Claims**. In the case of a post-service claim, the Plan shall notify the Claimant, in accordance with Paragraph d of this section, of the Plan's 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 or the PBM for up to 15 days, provided that the Plan or the PBM both determines that such an extension is necessary due to matters beyond the control of the Plan or the PBM and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

g. **Right of Review**

(1) **Full and Fair Review**. A Claimant who receives an adverse benefit determination with respect to any claim shall have the right to a full and fair review of that determination as required by law. For purposes of this Plan, an "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a Claimant's eligibility to participate in the Plan, and including 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 the service is determined to be experimental or investigational or not medically necessary or appropriate.

(2) **Time Frame for Seeking Review of an Adverse Benefit Determination**. A Claimant may institute review of an adverse benefit determination within 180 days of the Claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.

(3) The following procedures shall apply to any review sought by a Claimant concerning an adverse benefit determination under this Plan:

(a) The Claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

(b) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the

Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim shall be governed by the following: The document shall be "relevant" if it was relied upon in making the benefit determination, submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.

(c) The review of the adverse benefit determination shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(d) Review of the adverse benefit determination shall be give deference to the adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.

(e) If the adverse benefit determination was 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, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.

(f) The review process shall identify the medical or vocational expert, if any, whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(g) If a health care professional was consulted in connection with the adverse benefit determination, that person shall not be consulted in connection with the review of the adverse benefit determination.

(h) In the case of a claim involving urgent care, there shall be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's adverse benefit determination on review, shall be transmitted between the Plan or IBC and the Claimant or Claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

(4) **Right to Hearing Before the Retirement Committee**. The Retirement Committee, or a designated subcommittee of the Retirement Committee, shall, upon a claimant’s written request, conduct a hearing regarding the Claimant’s appeal from an adverse benefit determination. A Claimant or Claimant's authorized representative may appear

before the Committee or subcommittee to present any evidence or argument in support of the claim review.

(5) **Content of Claim Review Determination**. Each claim review determination shall be signed by at least two (2) Committee members authorized by the full Retirement Committee to resolve such claim review. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; and 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 the Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by Paragraph g(3)(b) of this section.

(6) **Time Frames for Claim Review Determination**. The following time frames shall apply to any rulings upon a requested claim review:

(a) **Urgent Care Claims**. In the case of a claim involving urgent care, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

(b) **Pre-Service Claims**. In the case of a pre-service claim, the Plan shall notify the Claimant in accordance with Paragraph e of this section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse benefit determination period.

(c) **Post-Service Claims**. In the case of a post-service claim, the ruling on the claim review shall not be made later than the date of the Retirement Committee's Meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Retirement Committee's Meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination shall be rendered not later than the third Retirement Committee's Meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan shall notify the Claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit

determination is made.

(7) **Furnishing Documents**. In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information as appropriate and required by law.

(8) **Definitions**. The following definitions shall apply herein:

(a) A claim involving "urgent care" means any claim for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations 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 a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon precertification or preauthorization by the Plan.

(c) The term "post-service claim" means any claim that is not a pre-service claim.

APPENDIX

In the pages that follow, you will find descriptions of the coverages provided under the Pre-65 hospital/medical/surgical, Medicare Supplement, dental benefit, vision benefit and prescription drug benefit programs.

The following summary of benefits applies to eligible retirees and/or their dependent spouse who are not yet eligible for Medicare coverage

	BlueCard PPO Program ***(Non-Medicare eligible participants)***	
	In Network	Out of Network*
Deductible (Individual)	$250	$500
Out-of-Pocket Maximum - Per Person	$500	$1,500
Coinsurance - Plan Pays	90% (100% after Out-of-Pocket Maximum is reached)	80%
Primary Care Office Visit Copay	$20, No deductible	80%, after deductible
Specialist Office Visit Copay	$30, No deductible	80%, after deductible
Maternity Care: - First OB Visit	$30, No deductible	80%, after deductible
Hospital Care - Maternity	90%, after deductible **	80%, after deductible
Inpatient Hospital Services	90%, after deductible **	80%, after deductible
Inpatient Hospital Days	365	70
Out-Patient Surgery	90%, after deductible **	80%, after deductible
Emergency Room Copay (Waived if Admitted)	$100, No deductible	$100, No deductible
Urgent Care Centers	$50, No deductible	$50, No deductible
Skilled Nursing Facility	90%, after deductible **	80%, after deductible
Out-Patient Radiology & Laboratory	90%, after deductible **	80%, after deductible
Physical, Speech, Occ. Therapy Co-pay per visit	$30, No deductible	80%, after deductible
Durable Medical Equipment and Prosthetics	90%, after deductible **	80%, after deductible

PLEASE NOTE THAT THE ABOVE BENEFIT OUTLINE IS MEANT ONLY TO HIGHLIGHT KEY FEATURES OF THE PLAN. PRE-AUTHORIZATION MAY BE REQUIRED FOR MANY OF THE SERVICES PROVIDED. REFER TO THE BENEFIT BOOKLET FOR MORE DETAILS ABOUT THE BENEFIT PROGRAM, AS WELL AS EXCLUSIONS AND LIMITATIONS.

**NOTE: ***Out-of Network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by the PPO, and the provider's actual charge. This amount may be significant.

**Plan pays 100% of the allowable charges after the yearly co-insurance out-of-pocket maximum for that patient is reached.

Under the Federal Medicare program, deductibles change yearly; your coverage under the plan changes accordingly to cover these deductibles;

Keep this document with your Summary Plan Description

TEAMSTERS JOINT COUNCIL NO. 53 RETIREE HEALTH AND WELFARE FUND

MEDICARE SUPPLEMENTAL COVERAGE - 2018 DEDUCTIBLES AND COINSURANCE

Medicare Part A - Hospital Services (per Benefit Period♦)

SERVICES	MEDICARE PAYS	SUPPLEMENT PLAN PAYS
HOSPITALIZATION		
Semiprivate room and board, general nursing and miscellaneous services and supplies.		
First 60 days	All but $1,340	$1,340
Days 61-90	All but $335/day	$335/day
After 90 days For 60 Lifetime Reserve days	All but $670/day	$670/day
After Lifetime Reserve days are used	$0	100% of Medicare eligible expenses for additional 365 days
Beyond the additional 365 days	$0	$0
SKILLED NURSING FACILITY		
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility with 30 days after leaving the hospital.		
First 20 days	100%	$0
Days 21-100	All but $167.50/day	$167.50/day
After 100 days	$0	$0

Notes:

- ♦ A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

Under the Federal Medicare program, deductibles change yearly; your coverage under the plan changes accordingly to cover these deductibles;

Keep this document with your Summary Plan Description

Medicare Part B - Medical Services (per Calendar Year)		
SERVICES	MEDICARE PAYS	SUPPLEMENTAL PLAN PAYS
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment.		
First $183 of Medicare-approved amounts	$0	$183
Remainder of Medicare-approved amounts	80% (50% of outpatient psychiatric services)	20% (50% of outpatient psychiatric services)
Part B excess charges (above Medicare-approved amounts)	$0	$0
Medicare Parts A and B - Services		
HOME HEALTH CARE - MEDICARE/APPROVED SERVICES		
Medically necessary skilled care services and medical supplies	100%	$0
Durable medical equipment First $183 of Medicare-approved amounts	$0	$183
Remainder of Medicare-approved amounts	80%	20%

UNITED CONCORDIA
Insuring America's Dental Health

CONCORDIA FLEX

Dental Benefits Summary for Teamsters Joint Council 53

Network: Advantage

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

Benefit Category[2]	Plan Pays[1]
Class I – Diagnostic/Preventive Services	
Exams	100%
Cleanings & Fluoride Treatments	
X-rays	
Sealants	
Space Maintainers	
Palliative Treatment (Emergency)	
Class II – Basic Services	
Basic Restorative (Fillings, etc.)	100%
Simple Extractions	
Endodontics	
General Anesthesia	
Class III – Major Services	
Surgical & Non-surgical Periodontics	N/A
Oral Surgery	
Inlays, Onlays, Crowns	
Prosthetics (Bridges, Dentures)	
Repairs to Inlays, Onlays and Crowns and Prosthetics	
Orthodontics (dependents to any age)	
Diagnostic, Active, Retention Treatment	N/A
Program Maximums/Deductibles	
Annual Program Maximum (per covered person)	$1,000
Lifetime Orthodontic Maximum (per covered person)	N/A
Annual Program Deductible (per person/per family)	N/A

1. The listed network percentages represent the portion of United Concordia's maximum allowable charges (MACs) for which the plan will be responsible. Network providers agree to accept United Concordia's MAC for covered services as payment in full and also agree to file claims for you. If you or your family members receive services from a non-network provider, United Concordia will apply the percentages shown to the [non-network reimbursement] for covered services and you will be responsible for the difference, up to the provider's charge. United Concordia's standard exclusions and limitations apply.
2. Unmarried dependent children covered to age 19. Unmarried dependent students covered to age 23. Disabled dependents covered to any age.

CONTACT UNITED CONCORDIA

Phone 1-800-332-0366
Customer service representatives are available from 8 a.m. to 8 p.m. ET.

Mail United Concordia, PO Box 69420, Harrisburg, PA 17103-9420

Web www.unitedconcordia.com
Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more!

TEAMSTERS JOINT COUNCIL #53
RETIREE H&W FUND

Managed Vision Care Option 1

$35.00 COPAYMENT PROGRAM

FREQUENCY OF SERVICE: **STUDENT AGE: 25**

	Member	Spouse	Children (to age 19)
Vision Exam	24 Months	24 Months	12 Months
Lenses	24 Months	24 Months	12 Months
Frames	24 Months	24 Months	24 Months

BENEFITS:

	VBA Participating Doctor OR (13,000 Nationwide)	**Non-Participating Doctor**
	Amount Covered *(Less Co-pay)*	Amount Reimbursed *(Zero Co-pay)*
Vision Exam	100% (after $10 co-pay)	$ 30.00
Clear Standard Lenses *(Pair)*:	(after $25 co-pay)	
Single Vision	100%	$ 30.00
Bifocal	100%	40.00
Trifocal	100%	60.00
Lenticular	100%	80.00
Polycarbonate Lens Material	100%	N/A
Frame	100%	$ 40.00

Frames are covered 100% within the program's $50 wholesale allowance *(approximately $100 to $135 retail)* when obtained from a VBA Participating Provider.

Note: Only one $25 co-pay applies to lenses, frames, or frames and lenses,

- OR -

Contacts *(Includes the vision exam allowance)*:		
Selected In Lieu of Glasses	$125.00	$ 125.00
Medically Required	UCR	250.00

Note: Contact exam is included in the contact lenses allowance of $125. There is no co-pay for contact lenses and the associated exam.

To locate a participating doctor or to obtain a Vision Claim voucher, call VBA at 1-800-432-4966.

TEAMSTERS JOINT COUNCIL NO. 53
RETIREE HEALTH AND WELFARE FUND

Express Scripts - Prescription Drug Coverage

	Formulary	Non-Formulary
Retail (30-day supply)		
Generic	$5 copayment	50% copayment
Brand Name	$20 copayment	50% copayment (minimum $30, maximum $50 copayment)
Mail Order (90-day supply)		
Generic	$10 copayment	50% copayment
Brand Name	$40 copayment	50% copayment (minimum $50, maximum $100 copayment)

You receive coverage for prescription drugs under this program when the drugs are prescribed by a licensed, practicing physician.

Your drug program uses a formulary, which is a defined list of selected drugs that have been evaluated for their medical effectiveness, positive results and value.

In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through mail order service for up to a 90-day supply. You will pay two times the copayment charged at the retail pharmacy. This benefit can save you time and money.

Some drugs require prior authorization. Your physician can initiate prior authorization for these medications if they are medically appropriate.

You may use any participating pharmacy to fill your prescription needs. Covered prescription drugs purchased at non-participating retail pharmacy will be reimbursed at 25% of the drug's retail cost.

Express Scripts Customer Service Number is 1-800-467-2006.

NOTES