TEAMSTERS LOCAL No. 377

HEALTH AND WELFARE FUND

SUMMARY OF BENEFITS

Teamsters Local No. 377
Health & Welfare Fund
(Downstairs Office)
1223 Teamster Drive
Youngstown, OH 44502
Phone: (330) 744-3148
Fax: (330) 744-4764

TEAMSTERS LOCAL No. 377 HEALTH AND WELFARE FUND

1223 Teamsters Drive • Youngstown, Ohio 44502 • (330) 744-3148

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
Ralph (Sam) Cook	Carmen G. Forde
Ken Sabo	Raymond A. Huber
Rich Sandberg	Joseph J. Kerola

FUND ADMINISTRATOR

Compensation Programs of Ohio, Inc.

FUND CO-COUNSEL

Faulkner, Hoffman & Phillips, LLC

Marcus & Shapira, LLP

FUND AUDITOR

Anness, Gerlach & Williams, Certified Public Accountants

TEAMSTERS LOCAL 377 HEALTH & WELFARE FUND

1223 TEAMSTERS DR., YOUNGSTOWN, OH 44502 **(330) 744-3148**

MEDICAL MUTUAL OF OHIO

2060 EAST NINTH ST., CLEVELAND, OH 44115 **(800) 426-6158**

SUMMARY OF BENEFITS

BENEFIT	MAXIMUM PAYABLE
Life Insurance	**$ 25,000.00**
Accidental Death & Dismemberment	**$ 25,000.00**
Accident and Sickness Time Loss Benefit Maximum Term	**$ 200.00 per week – maximum of 26 weeks**

**** Above benefits apply to Employee only****

Benefits	**Network**	**Non-Network**
Benefit Period	January 1st through December 31st	
Dependent Age	**26** Removal upon End of Month	
Benefit Period Deductible – Single/Family[1]	$500 / $1,000	$1,000 / $2,000
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$5,000 / $10,000	
Lifetime Maximum	Unlimited	
4 Month Deductible Carryover	Applies only for period of September 1, 2012 – December 31, 2012	
Physician/Office Services		
Office Visit to PCP (Illness/Injury)[2]	$20 copay, then 100%	60% after deductible
Specialist Office Visit (Illness/Injury)[2]	$40 copay, then 100%	60% after deductible
Urgent Care Office Visit [2]	$20 copay, then 100%	60% after deductible
Diagnostic Services - rendered in the Physician's Office	100%	60% after deductible
Immunizations (All Tetanus Toxoid Vaccines – Illness/Injury)	80% after deductible	60% after deductible
Immunizations	100%	60% after deductible
Preventive Services		
Preventive Service in accordance with federal law[3]	100%	60% after deductible
Routine Adult Physical Exams (Ages 21 and over; One per calendar year)	100%	60% after deductible
Well Child Care Services including Exams (7 exams in 1st 12 months), Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (up to age 21)	100%	60% after deductible
Routine Mammogram	100%	60% after deductible
Routine Gynecological Exam (One exam per calendar year)	100%	60% after deductible

Benefits	Network	Non-Network
Routine EKG, Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100%	60% after deductible
Cholesterol Screening, Prostate Specific Antigen (PSA), Colon Cancer Screening (All Ages)	100%	60% after deductible
Influenza Virus Vaccine (All ages)	100%	60% after deductible
Endoscopic Services[4]	100%	60% after deductible
Preventative Immunizations (Age 21 and over)	100%	60% after deductible
Routine Audiometric (Hearing) Examination	100%	60% after deductible
Outpatient Services		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Services – rendered other than a physician's office	80% after deductible	60% after deductible
Physical Therapy, Occupational Therapy and Chiropractic - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	60% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Emergency use of an Emergency Room[5]	$100 copay, then 80% after deductible	
Non-Emergency use of an Emergency Room	Not covered	Not covered
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	60% after deductible
Maternity (limited to EE and SP only)	80% after deductible	60% after deductible
Skilled Nursing Facility (730 day w/90 day renewal; prof svcs unlimited)	80% after deductible	60% after deductible
Organ Transplants (includes professional services)	80% after deductible	60% after deductible
Additional Services		
Allergy Testing	80% after deductible	60% after deductible
Allergy Treatments	80% after deductible	60% after deductible
Case Management	100%	100%
Emergency use of Ambulance	80% after deductible	60% after deductible
Non-emergency use of Ambulance	Not covered	Not covered
Oral Accident	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Jobst/Compression Stockings	80% after deductible	60% after deductible
Home Healthcare	80% after deductible	60% after deductible

Benefits	Network	Non-Network
Hospice	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse Office Visit	$20 copay, then 100%	60% after deductible
Hearing Aid Benefit		
Conformity Evaluation (1 every rolling 36- months)	100% up to $150.00 maximum ($150 maximum combined with Hearing Aid Evaluation Test)	
Hearing Aid (1 per ear every rolling 36-months)	80% after deductible (up to $1500 maximum per appliance per ear)	
Hearing Aid Evaluation Test (1 every rolling 36-months)	100% up to $150.00 maximum ($150 maximum combined with Conformity Evaluation)	

Network services will apply to only the Network deductible. Non Network services will apply to only the Non-Network deductible.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

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[1]Maximum family deductible. Member deductible is the same as single deductible.
[2]The office visit copay applies to the cost of the office visit only.
[3]Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
[4]Incidental services related to endoscopic services are subject to the Plan's network and non-network benefits. Examples of incidental services include facility charges, anesthesia and pathology.
[5]Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

PRIMARY CARE PROVIDERS SUBJECT TO $ 20.00 Co Pay

- **General Practice**
- **Family Practice**
- **Internal Medicine**
- **Obstetrics and Gynecology (OB/GYN)**
- **Pediatrics/Neonatology**
- **Certified Nurse Practitioner/Physician Assistant**
- **Geriatric**
- **All Travel/Other Network Providers**
- **Psychiatry**
- **Geriatric Psychiatry**
- **Child and Adolescent Psychiatry**
- **Addiction Psychiatry**
- **Psychology**
- **Licensed Independent Social Worker**
- **Licensed Professional Clinical Counselor**
- **Licensed Marriage – Family Therapist**

All other providers will be considered specialists and are subject to the $ 40.00 Co Pay

BENEFITS PROVIDED BY THE FUND OFFICE

COMBINED DENTAL AND VISION SERVICE BENEFIT

Maximum for single policy: **80% of $1,250.00 per calendar year**

Maximum for family policy: **80% of $1,250.00 per calendar year**

(Dependents under age 19 no limit)

The Fund will consider all dental and vision services with no restrictions on frequency for covered procedures provided by a licensed Dentist, Physician or Vision Supplier up to the maximum allowance stated above.

Special prescription lenses or contact lenses, which are required to correct cataract surgery, and extensive eye examinations by an ophthalmologist because of a disease of the eye, are covered separately under the major medical benefit.

Eligibility rules for dental and vision benefits are the same as those for other benefits under the Plan. Benefits will be paid only for services, which are performed while the covered person is eligible.

ORTHODONTIC BENEFIT

Lifetime maximum: **$1,000.00 per individual**

Orthodontic services will be covered for a all eligible participants and their dependents up to the Lifetime maximum.

CAREBRIDGE COORPORATION, EMPLOYEE ASSISTANCE (EAP)

1.800.437.0911 **www.myliferesource.com** **Access code: KF7M5**

The Fund offers an Employee Assistance Program through Carebridge Corporation for family, financial, legal, and emotional or other personal problems for all eligible member and their eligible dependents who **DO NOT** have an employee assistance program available to them through their employer.

Carebridge and its network of skilled EAP counselors offer you a choice of either face-to-face or convenient scheduled telephone consultations. Each counselor is trained, credentialed, and experienced in helping you or your eligible dependent. Carebridge can help 24 hours per day, 7 days per week with issues such as:

Marital Relationships, Grief and Loss, Alcohol Problems, Financial Pressures, Stress Management, Difficult Emotional Issues, Family/Parenting Relationships, Spousal/Child/Parent abuse, Drug Problems, Work Relationships, Depression and Anxiety, Smoking Cessation.

PRESCRIPTION DRUG BENEFIT

Express Scripts, Inc.
P.O. Box 66583, St. Louis, MO 63166

www.express-scripts.com
1.800.467.2006

Generic Preferred Program: If you choose the generic, your copayment will be the cost of your prescription up to $15.00. If you choose the brand-name, you will pay a copayment of $15.00 ***plus*** the difference in cost between the generic and the brand-name drug even if your physician indicates dispense as written.

Step Therapy Program: Step Therapy encourages the use of generic medications.

- Step 1 – Try the front-line generic or lower-cost brand medication, proven to be safe, effective and affordable.
- Step 2 – If the front-line generic does not work for you, you will automatically be able to fill the more expensive brand-name back-up medication.

	RETAIL PHARMACY	MAIL ORDER
Generic Drugs	$ 15.00 Co-Pay	$ 30.00 Co-Pay
Brand Formulary	$ 30.00 Co-Pay	$ 60.00 Co-Pay
Brand Non-Formulary	$ 60.00 Co-Pay	$120.00 Co-Pay
Generic Oral Contraception	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Brand Formulary and Non-Formulary Oral contraception will continue to be subject to medical necessity, Co-Pay applies	
Generic OTC Aspirin	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Men ages 45 to 79 years and women ages 55 to 79. To prevent cardiovascular disease. Physicians prescription required.	
Generic Fluoride Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Preschool children older than 6 months of age through 5 years old. Physician prescription required.	
Generic Folic Acid OTC/Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Women of child bearing age (18 to 45). Physician prescription required.	
Generic Iron Supplements OTC/Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Children ages 6 to 12 months who are at increased risk for iron deficiency anemia. Physician prescription required.	

EXCLUSIONS

Fertility drugs, Smoking cessation drugs, Genetically Engineered drugs, Immune Altering drugs, and Non-Generic Federal Legend Oral Contraceptives will be excluded. (Some exceptions apply. Please contact the Fund Office for further information).

PHARMACY EXCLUSIONS

☆Wal-Mart ☆Walgreens ☆Marc's

The ESI card is not valid at these pharmacy chains nor will there be any reimbursement eligibility for non-emergency prescriptions.

In the event that a network pharmacy is not available for medical emergencies a claim may be submitted directly to the Fund office for consideration of reimbursement minus the applicable co-payment.

WEEKLY DISABILITY BENEFIT

This benefit is payable as a wage replacement if you become totally disabled and cannot work due to either an accidental bodily injury or a sickness, not connected with your employment. You must be under the regular and direct care of a licensed physician or surgeon who certifies that you are totally disabled. Benefit payments will begin with the first day of disability in the event of an accident or the eighth consecutive day in the event of sickness, but will not be paid for more than 26 weeks for each period of disability.

Successive periods of disability will be considered as one continuous period of disability if they are due to the same or related causes and are not separated by a return to active work for at least six weeks. However, if you return to active work for at least six weeks between periods of disability which are due to the same or related causes, or if the periods of disability are separated by return to active work and are due to different and unrelated causes, then each disability will be considered separately, and benefits will be payable up to 26 weeks for each disability.

EXCLUSIONS FOR WEEKLY DISABILITY BENEFITS

Disabilities not covered are those for any period that you are entitled to primary benefits under the Federal Social Security Act and amendments thereto.

Disabilities not covered are those that result from attempted suicide or self-inflicted injury or illness, injury sustained during or as a result of the commission, or attempt to commit a criminal act, as determined by the Board of Trustees.

LIFE INSURANCE BENEFIT (For Employees Only)

In the event of your death at any time or place while you are covered under the Fund, a benefit in the amount indicated on the Summary Of Benefits will be paid in a lump sum to the beneficiary you have named. However, no benefit will be paid for death by suicide.

Should you fail to name a beneficiary, or if the beneficiary you have named is not living at the time of your death, this benefit will be paid in the following order of preference to:

1. Your spouse
2. Your children,
3. Your parents

YOU MAY CHANGE YOUR BENEFICIARY WHENEVER YOU WISH BY COMPLETING THE APPROPRIATE FORM AVAILABLE AT THE FUND OFFICE. YOU MUST DO THIS IN PERSON.

Should you die within 31 days after your eligibility ends, the death benefit will be paid just as if you were eligible at the time of your death.

If prior to 60 you become totally and permanently disabled, your life insurance will continue without cost for a period of twelve months. Proof of total and permanent disability must be presented within the twelve-month period, and yearly thereafter, to continue the insurance in force.

Because of the self-insured status of the Fund, this life insurance benefit cannot be converted to individual coverage.

The Fund is not obligated to notify you or your beneficiary of any termination of coverage.

ELIGIBILITY

This section tells how to apply for coverage, how and when you become eligible for coverage, who is considered a Dependent, and when your coverage starts. This section also explains when you should change from individual to family coverage and how you should apply for the change.

To enroll you must complete an application card, but no physical examination is required. You can enroll for either individual or family coverage. You will receive an identification card from Medical Mutual of Ohio, which shows your identification number. If you have family coverage, it is important for you to know which family members are eligible for benefits.

You can become eligible for the benefits provided under the Teamsters Local No. 377 Health and Welfare Fund if:

- You are a member of the bargaining unit represented for purposes of collective bargaining by Local No. 377, and
- Your employer has entered into a collective bargaining agreement with Local No. 377 of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers, providing for contributions to be made to the Health and Welfare Fund, and is required to and actually makes the necessary contributions on your behalf to the Health and Welfare Fund, and
- Your employer has signed a written agreement with the Board of Trustees authorizing the necessary contributions to be made on your behalf.

You are not eligible if you are an employer, partner, self-employed person, proprietor, or a dependent of such an individual.

Coverage Begins

Coverage starts on your effective date, which is determined as follows:

If you begin work for a contributing employer who has participated in the Fund for at least three months, your effective date will be contingent upon the receipt of two full consecutive monthly contributions from a contributing employer on your behalf. (Most employers pay contributions based on weeks worked. Therefore, a full contribution includes all weeks for that month). The following schedule reflects a participants effective date based on the first month of contributions made.

Example: Employer's initial contributions are the full months of December and January participants' effective date is March 1st.

First full monthly contribution:	First month of coverage will be:
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February

You can also become eligible if the Fund has received 9 weeks of contributions within a 12-month period from a contributing employer. The corresponding chart below reflects a participant's eligibility date based on the 9th weekly contribution.

> **Example:** Employer's 9th week of contributions is the week ending 01/11/03
> participants' effective date is 03/09/03

TERMINATION/REINSTATEMENT OF COVERAGE

When an employer is not responsible to make contributions, coverage will actually be extended through the end of the 9th week immediately following the last full weekly contribution. You will then be given self-pay options to continue their coverage.

> **Example:** Employer ceases to make contributions the week ending 01/11/03
> benefits will terminate 03/09/03

If you return to work for a contributing employer within 24 months of the date on which your eligibility was terminated your coverage will be reinstated immediately following the end of the 9th week following your return to work. (Or the corresponding week two months ahead)

> **Example:** Employer begins making contributions the week ending 01/11/03 for an employee returning from lay-off benefits will be reinstated 03/09/03.

If initial 9 weeks, layoff or return from layoff occurs:	**9th week of initial eligibility last contribution or return to work: (weeks ending)**	**Date coverage will begin, end or reinstate:**
January	04,11,18,25	03/02,09,16,23
February	01,08,15,22	03/30, 04/06,13,20
March	01,08,15,22,29	04/27, 05/04,11,18,25
April	05,12,19,26	06/01,08,15,22
May	03,10,17,24,31	06/29, 07/06,13,20,27
June	07,14,21,28	08/03,10,17,24
July	05,12,19,26	08/31, 09/07,14,21
August	02,09,16,23,30	09/28, 10/05,12,19,26
September	06,13,20,27	11/02,09,16,23
October	04,11,18,25	11/30, 12/07,14,21
November	01,08,15,22,29	12/28, 01/ 04,11,18,25
December	06,13,20,27	02/01,08,15,22
Weeks based on 2003 calendar for example only		

Continuing Eligibility:

In order to remain eligible for coverage for each month, your employer must make contributions for all weeks of that month. Otherwise, you must make self-contributions for coverage as described in the section on self-contributions.

Self-Contribution:

You may continue your benefits in force for an additional period of 2 months immediately following your termination date, if you pay in advance the contribution required by the collective bargaining agreement applicable to your employment. Payment must be made to the Fund Office by the date indicated on the continuation of coverage options notification.

The amount of payment required for these two months will be calculated at 50% of the current Cobra Rate. This limit of two consecutive months will be upon each unemployment period with no limit on the number of two-month periods.

As an example, let's assume you are laid off on January 14, 2006. Once your eligibility period ends on March 19, 2006, you will be entitled to pay the remainder of that month at the current employer rate or begin your self-payment period. At the end of your second month of self-payments, you will be entitled to continue your benefits through COBRA or, if eligible for the Retiree Plan, begin the retiree self-pay program. If you become re-employed and establish eligibility, you will become eligible again for the two-month self-pay period.

If you wish to continue eligibility for the Plan's hospitalization, surgical, medical and major medical benefits only, you will be notified by the Fund Office of your options and the cost of such coverage as soon as your employer has ceased to make contributions on your behalf. At the time of your termination of coverage you must elect the amount of coverage you wish to continue and you cannot change the coverage you elected during the self-contribution period.

This self-contribution privilege is not available to you if the reason that you are no longer insured is because your employer is no longer required to make contributions to the Fund. In other words, if your employer has left the Fund and is therefore no longer considered a contributing employer, you become ineligible to self-contribute to maintain benefits, unless the contributing employer left the Fund due to the termination of business, or unless you were already self-contributing at the time the employer terminated his contributions to the Fund.

Termination:

When you stop being an eligible person or do not pay the required contribution, coverage stops for all covered persons at the end of the period for which payment was made. Coverage stops for a dependent on the date that person no longer meets the definition of dependent.

You will stop being an eligible person upon the occurrence of any of the following:

- The date you enter the military;
- The date you cease to be a member in good standing with the Local Union;
- The end of the 9th week immediately following the last full weekly contribution received from your employer
- The last day of the month for which you cease to make self contributions
- The Fund has the right to void the coverage of any covered person who engages in fraudulent conduct relating to claims or application for coverage, as determined by the Fund

You are responsible for notifying the ***Plan*** of any of these above-mentioned terminating events.

Certificate of Creditable Coverage Available After You Lose Coverage Under This Health & Welfare Plan

When you become covered under a new medical plan or another welfare plan or insurance policy that contains a pre-existing conditions provision, the exclusion period is reduced by your "creditable coverage." If you request (or authorize others to request) certification from this Plan within 24 months of the date your coverage terminated, the Plan will provide you with a certificate documenting the period of time you were covered by this Plan. Provided there is no more than a 63 day break in coverage, the time you were covered by this Plan may reduce the pre-existing conditions period under the new plan.

Changes in Coverage:

If you applied for individual coverage, you can change to family coverage if you marry or add a child. The date coverage is effective for a spouse or child depends upon when the Fund is notified, so tell us promptly. **Failure to promptly notify the Fund office about adding a spouse or child can result in a long delay in that person's eligibility for coverage.**

Family coverage should be changed to individual coverage when only the employee is eligible. In addition, the Fund should be notified when a covered person becomes eligible for Medicare.

Dependent Eligibility:

Eligible Dependents include:

- Your wife or husband, unless legally separated;
- Your dependent children, step children, and adopted children through the end of the month of their 26th birthday regardless of marital status or the availability of other group health coverage through their employer;
- Your unmarried children who can't work to support themselves due to mental retardation or physical handicap. The disability must have started before the end of the month in which the child reaches the age limit when eligibility would otherwise have ended.

Eligibility For Retirees

The following eligibility rules must be met in order for a Retiree between the ages of 55 and 65 to qualify for Retiree Health Insurance Benefits. These benefits are being provided in part through current contributions being paid on behalf of active members covered under this Welfare Fund and direct Retiree contributions.

In order for a Retiree to be eligible for these benefits, it is necessary to meet the following requirements:

1. The Retiree must be at least age 55 and have been an eligible active employee under the Health and Welfare Fund for at least 9 full years of the 12 years immediately prior to his termination as an active employee on or after age 55. The Retiree must have been covered by this Health and Welfare Fund for a period of at least 2 full years as an active employee immediately prior to age 55, if previously covered by another Teamster Industry health insurance fund or employer paid plan negotiated with Teamsters Local 377.

2. The Retiree must have been in covered employment as an active employee for which contributions were paid under the Teamsters Central States Pension Fund, other teamster pension fund or Local No. 377 negotiated employer pension plan immediately prior to age 55, and earned sufficient credit to retire at that date or at a later date.

3. The Retiree must pay the required monthly contribution established by the Board of Trustees within the required time.

For further information regarding retirement eligibility requirements please contact the Fund office.