Teamsters Western Region & Local 177
Retiree Health Care Plan

RETIREE BENEFITS SEMINAR

2024

www.wr177healthcare.com

What Is Our Retiree Health Care Plan?

The Teamsters Western Region & Local 177 Retiree Health Care Plan is designed to provide affordable coverage for retired Teamster members and their families and easy access to a wide range of health care services. Health care benefits offered to Pre-Age 65 Retirees and Medicare-eligible participants include:

- **Comprehensive Medical and Behavioral Health**
- **Prescription Drugs**
- **Dental**
- **Vision**

Coverage in the Retiree Health Plan is also available to:

- **Eligible Family Members:** Retirees may opt to cover spouse and dependent children.
  - **Legal Spouse and Surviving Spouse** - If Retiree dies before their spouse, the spouse may be able to maintain coverage for life or until they remarry.
  - **Dependent Children** - Dependents will be covered up to age 19 or up to age 25 if a full-time student.

Eligibility

You are eligible for the Teamsters Local 177 Retiree Health Care Plan if:

- You participated in the Teamsters Western Region and Local 177 Health Care Plan (or a predecessor) for 30 of the 48 months preceding retirement and
- You have at least 10 years of credited service with a Contributing Employer to the Teamsters Western Region and Local 177 Health Care Plan and
- You are eligible and retire under a Disability, Normal, and/or PEER Pension from the Western Conference of Teamsters Pension Fund.
- You cannot have a gap in coverage between the Active Plan to the Retiree Health Plan.

NOTE: Your coverage under the Teamsters Western Region & Local 177 Retiree Health Care Plan will continue when you become eligible for Medicare. **Once eligible, you must enroll in Medicare Parts A and B.** Medicare will become the primary payer for your medical expenses and the Plan will pay benefits secondary to Medicare. **If you do not enroll in Medicare Parts A and B, your benefits will still be reduced as if you were covered by Parts A and B.**

In the near future, if you are eligible for Medicare, this Retiree Health Care Plan will not be available until enrolled in Medicare Parts A and B.

Dependent Eligibility

- Dependent Child(ren), Spouse
- “Children” generally includes, up to age 19 (or up to age 25 if enrolled as a full-time student), children, step-children, adopted children.
- Unmarried Dependent Children who are incapable of self-sustaining employment by reasons of mental or physical disability and who are receiving Social Security disability benefits (SSI) will continue to be covered, provided such incapacity and SSI benefits commenced while the child was an eligible Dependent prior to the end of the month the child attains age 19 (or age 25, if full-time student) and the child depends on the Retiree for support and maintenance. **Notification of such disability must be submitted within 31 days prior to the date coverage would otherwise end.**
- If you have a child while covered under the Plan, coverage begins at birth, provided you notify the Administrative Office within 90 days and you provide the necessary Proof of Dependent Status.
- Newly acquired spouses **cannot** be added after your initial enrollment.

Medical—Aetna / BlueCrossBlueShield of Arizona

The deductible applies to all benefits in this Schedule unless noted otherwise.	In-Network*	Out-of-Network
Annual Deductible (Includes prescription drug and behavioral health expenses)	$200 individual $400 family	$200 individual $400 family
Annual Out-of-Pocket Maximum (Includes prescription drug and behavioral health expenses)	$1,000 individual $2,000 family	None
PREVENTIVE CARE		
Routine Physical Exam	Plan pays 80%, you pay 20%	Not covered
Well-Child Care	Plan pays 80%, you pay 20%	Not covered
Routine Mammogram	Plan pays 80%, you pay 20%	Not covered
Routine GYN Exam	Plan pays 80%, you pay 20%	Not covered
OUTPATIENT CARE (Non-Preventive Care)		
Physician's Office Visit	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%
Chiropractic Care	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
Hearing Services (Covered up to $3,000/ear every 4 yrs) *One hearing aid/ear annually for covered dependent children*	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
Outpatient Surgery	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%
X-Ray and Lab Tests	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%

***To find an In-Network medical provider in your area, go to www.aetna.com or www.bcbsaz.com**

IMPORTANT: Out-of-Network Providers are paid according to the Allowed Charge as defined in the SPD and could result in balance billing to you.

Medical—Aetna / BlueCrossBlueShield of Arizona

The deductible applies to all benefits in this Schedule unless noted otherwise	In-Network*	Out-of-Network
Annual Deductible (Includes prescription drug and behavioral health expenses)	$200 individual $400 family	$200 individual $400 family
Annual Out-of-Pocket Maximum (Includes prescription drug and behavioral health expenses)	$1,000 individual $2,000 family	None
INPATIENT CARE		
Inpatient Hospitalization	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%
Inpatient Surgery	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%
Skilled Nursing Facility	Plan pays 80%, you pay 20%	Plan pays 70%; you pay 30%
EMERGENCY CARE		
Emergency Room	Plan pays 80%, you pay 20%	
MENTAL HEALTH AND SUBSTANCE ABUSE CARE		
Mental Health—Inpatient	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
Mental Health—Outpatient	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
Substance Abuse Treatment	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
PRESCRIPTION DRUG COVERAGE		
Retail Pharmacy (30-day supply)	Plan pays 80%; you pay 20%	Plan pays 70%; you pay 30%
Mail-Order Program (90-day supply)	Plan pays 80%; you pay 20%	N/A

***To find an In-Network medical provider in your area, go to www.aetna.com or www.bcbsaz.com**

IMPORTANT: Out-of-Network Providers are paid according to the Allowed Charge as defined in the SPD and could result in balance billing to you.

Some Important Things to Remember

- Coinsurance amounts apply ***after*** meeting your deductible.

- Annual Out-of-Pocket Maximum ***includes*** your deductible and the 20% coinsurance you pay toward your in-network medical, prescription drug and behavioral health expenses.

- For medical services received out-of-network, you are responsible for your coinsurance ***plus*** any amounts your provider charges above the Plan's allowed charges.

- Out-of-network charges do not apply to the out-of-pocket maximum, except for non-network emergency services performed in an Emergency Room.

Rx—CVS Caremark

- Prescription Drug coverage is provided through CVS Caremark— giving you access to the very same network you used in the Active Plan.
- The CVS Caremark network includes most pharmacy chains.
- When you use an in-network retail pharmacy or the mail order program the plan pays 80% after deductible is met.
- When you use an out-of-network retail pharmacy the plan reimburses you 70% of the Allowed amount after deductible is met. You pay 30% plus any amount over the Allowed amount.
- The pharmacy benefit includes: 1) mandatory generic drug policy, 2) access to Mail Order (Home Delivery), 3) access to Specialty Drugs and 4) a Step Therapy Program.
- Please note that Quantity Limits apply for certain medications.
- Certain medications will require Prior Authorization, and it should be noted that the Preferred Drug Formulary List is updated on a quarterly basis.

To find a participating pharmacy in your area, go to www.caremark.com and create your account.

Rx—Mandatory Generic Requirement and Mail Order

- **Mandatory Generic Requirement:** If a generic equivalent is available, you must take the generic or be responsible for the cost difference between the price of the brand name drug and the generic drug plus the co-payment.
- **Mail Order (Home Delivery):** Maintenance Medications may be available to you through mail order. Have your doctor write your prescription for a 90-day supply, with the appropriate refills. Your doctor may coordinate your 90-day prescription with Mail Order or you may mail your documents. See your ID Card for more details. *Please allow up to 14 days to receive your order.*
  - Mail Order: Caremark.com/StartNow
- Out-of-Network Mail Order is <u>not covered.</u>

Rx—Specialty Drugs

- Specialty Drugs are available through CVS Specialty. Specialty medications are considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed:
- Specialty drugs are designed to target and treat specific diseases, such as arthritis, asthma, cancer, diabetes, hemophilia, hepatitis, HIV, and multiple sclerosis.
- Specialty drugs are primarily self-injectable medications requiring patient training and education.
- These drugs need precertification because they often require special handling, are date sensitive and are usually available only in a 30-day quantity.
- To ensure that you are prescribed the right specialty medication at the right dosage, you are required to obtain prior authorization from CVS Specialty before it can be dispensed.
- You can obtain the Specialty Drug formulary (list of drugs) by contacting CVS Specialty at (800) 237-2767.

Rx—Step Therapy

- The Fund's Step Therapy Program is designed to ensure you take safe and cost-effective medications to treat certain conditions. The program promotes the use of generic medications because they are just as safe and effective as brand-name medications, but cost much less.
- The Step Therapy Program steers members to take a first-step medication prior to coverage of a second-step medication, and to take a second-step medication prior to coverage of a third-step medication.
- It also includes cholesterol-lowering drugs (statins), sleep aids, SSRI antidepressants, COX-2 anti-inflammatory drugs and steroid nasal sprays.
- If you are diagnosed with any of these issues, your doctor might initially describe a generic or first-step medication, and together you would assess its effectiveness. If effective, there would be no need to escalate your treatment to a second-step medication.

Dental—Aetna

The Plan recognizes the importance of healthy teeth and gums to your overall health. Through the Aetna Dental network routine check-ups are 100% covered with no copays and no deductible to meet when you visit a participating provider, as shown below.

	In-Network	Out-of-Network
Annual Deductible	None	None
Preventive and Basic Services	Plan pays 100%; no cost to you	Plan pays 80% of Allowed Charges
Major Services	Plan pays 80%	Plan pays 80% of Allowed Charges
Annual Maximum Benefit (per Calendar Year; orthodontia not included)	$1,500 per person	
Child Orthodontia	Plan pays 50% up to a lifetime maximum of $1,500	Plan pays 50% of Allowed Charges up to a lifetime maximum of $1,500

To find an In-Network Dental Provider in your area, go to www.aetna.com

Dental—Aetna Limited to $1,500 per person per calendar year

Dental services (In-Network) Classifications and Limitations

- **Type A (covered 100% In-Network)**:
  - **Office visits** during regular office hours, oral examination.
  - **Prophylaxis** (cleaning) 2 treatments per year combined with periodontal maintenance.
  - **Topical application of fluoride** (2 courses of treatment per year for children to the end of the calendar month in which the child turns age 15 years).
  - **Sealants,** per tooth, limited to one application every 3 years for first and second permanent molars only and to children to the end of the calendar month in which the child turns age 14 years.
  - **Bitewing x-rays** (limited to 2 sets per year).
  - **Complete x-rays** including bitewings if necessary, or panoramic film (limited to one set every 3 years).
  - **Vertical bitewing x-rays** (limited to one set every 3 years).
  - **Space maintainers** only when needed to preserve space resulting from premature loss of primary teeth (includes all adjustments within 6 months after installation and limited to children up to age 19).
  - Intra-oral, occlusal view, maxillary or mandibular.
  - Upper or lower jaw, extra-oral

Dental—Aetna Limited to $1,500 per person per calendar year

Dental services (In-Network) Classifications and Limitations

- **Type B (covered 100% In-Network)**:
  - **Visits and X-Rays** - Emergency palliative treatment, per visit
  - **X-Ray and Pathology** - Periapical x-rays (single films up to 13)
  - **Periodontics**
    - Root planing and scaling, per quadrant (limited to 4 separate quadrants every 12 months)
    - Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 12 months)
    - Periodontal maintenance procedures (limited to 2 per year combined with prophylaxis)
  - **Endodontics**
    - Pulp capping; Pulpotomy; Apexification/recalcification,
    - Root canal therapy including necessary X-rays (Anterior or Bicuspid)
  - **Restorative Dentistry** Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
    - Amalgam restorations, Resin-based composite restorations, Pins (Pin retention—per tooth, in addition to amalgam or resin restoration
    - Crowns (when tooth cannot be restored with a filling material)
    - Recementation (Inlay or Crown or Bridge)
  - **Prosthodontics**
    - Special tissue conditioning, per denture,
    - Adjustment to denture more than 6 months after installation
    - Full and partial denture repairs
    - Adding teeth to existing partial denture

Dental—Aetna Limited to $1,500 per person per calendar year

Dental services (In-Network) Classifications and Limitations

- **Type C (covered 80% In-Network)**:
  - **Oral Surgery:** Surgical removal of impacted teeth, Removal of tooth (partially bony), Removal of tooth (completely bony), Surgical removal of erupted tooth/root tip
  - **Impacted Teeth:** Removal of tooth (soft tissue)
  - **Odontogenic Cysts and Neoplasms:** Incision and drainage of abscess, Removal of odontogenic cyst or tumor
  - **Other Surgical Procedures:** See Summary Plan Description
  - **General Anesthesia and Intravenous Sedation:** (only when medically necessary and only when provided in conjunction with a covered surgical procedure) Oral Surgery, Impacted Teeth, Other Surgical Procedures, General Anesthesia and Intravenous.
  - **Orthodontia Services (covered 50%):** Limited to $1,500 per dependent child per lifetime.
  - **Out-of-Network:** Type A, B, and C services are reimbursed at 80% of Allowed Charges up to the calendar year maximum. Orthodontia services are reimbursed at 50% of Allowed Charges up to the lifetime maximum.

Vision—VSP | Deductible does not apply

Protecting your eyesight is easy with VSP. Vision benefits are available **once every calendar year** for you and your covered dependents.

	In-Network	Out-of-Network**
Eye Exam	After $10 copay, Plan pays 100% *No copay if you use VSP Premier Edge Vision Providers*	After $10 copay, Plan pays 100% up to $40
Single-vision Lenses	Plan pays 100%* *Anti-Glare Coating covered at 100% with VSP Premier Edge Vision Providers*	Plan pays 100% up to $30
Lined Bifocal Lenses	Plan pays 100%* *Anti-Glare Coating covered at 100% with VSP Premier Edge Vision Providers*	Plan pays 100% up to $40
Lined Trifocal Lenses	Plan pays 100%* *Anti-Glare Coating covered at 100% with VSP Premier Edge Vision Providers*	Plan pays 100% up to $50
Lenticular Lenses	Plan pays 100%* *Anti-Glare Coating covered at 100% with VSP Premier Edge Vision Providers*	Plan pays 100% up to $60
Frames	Plan pays 100% up to $180 retail value; 20% discount on amount over allowance. *Extra $50 frame allowance with VSP Premier Edge Vision Providers*	Plan pays 100% up to $30
Contact Lenses (in lieu of glasses)	Cover up to $150 allowance for contacts & contact lens exam (fitting and evaluation) 15% off contact lens exam(fitting and evaluation) **Medically Necessary: No charge**	Plan pays 100% up to $60
Low Vision Services	Maximum Allowance $1,000/ person every 2 years Supplemental testing covered in full. Supplemental Aids 75% of the cost	Supplemental Testing 100% up to $125 Supplemental Aids 75% of the cost

* For frames over the allowance and non-covered lens enhancements, you will be responsible for additional charges, but at reduced VSP pricing.

** Services by a non-VSP provider are subject to Plan's Allowable Charges. .

To find a Vision provider in your area, go to www.vsp.com

Transcarent/98point6 On-demand, text-based primary care

The 98point6 platform provides on-demand visits which allows members to immediately start a visit, any time, from anywhere.

When to use 98point6	Available 24/7/365 for Non-urgent concerns
Cost	$0/Visit
Access	Easy access via mobile device **98point6 App** App Store or Google Play
Support for other languages besides English	Providers are supported by interpreters in over 350 languages who connect with the patient via audio within the app to assist with your medical evaluation

To connect with 98point6, go to www.98point6.com/twr
Or Call 866.657.7991

Monthly Contribution Rates

Coverage is convenient, high quality and **affordable** to you and your family. The monthly contribution amounts depend on whether you are eligible for Medicare, as shown below.

	RETIREE MONTHLY CONTRIBUTION RATES:		
	NON-MEDICARE ELIGIBLE (PRE-AGE 65)	NON-MEDICARE ELIGIBLE ONE MEDICARE ELIGIBLE /ONE NON-MEDICARE	*MEDICARE ELIGIBLE (POST-AGE 65)
	SINGLE/FAMILY	ONE NON-MED ELIG ONE MED ELIG	SINGLE/FAMILY
	$150/$300	$200	$50/$100

To avoid termination of your medical coverage, the monthly self-payment must be received no later than the 15th day of the month prior to the month in which coverage is desired. It will be your responsibility to make sure your monthly payment is received on time. To learn more about direct payment, please visit **www.wr177healthcare.com** and print a direct payment authorization form.

Medicare eligible **YOU MUST APPLY FOR MEDICARE.**

When to Apply

- Eligible Retirees must complete the necessary written application and submit it to the Administrative Office of the Fund ***within 60 days of retirement.***
- A Retiree's eligibility starts on the earlier of the following dates:
  - The date on which his/her eligibility as an active employee under the Teamsters Western Region and Local 177 Health Care Plan terminates, if he/she is eligible as a Retiree as of such date, or
  - The first day of the month pension or disability benefits become payable to the Retiree.

If you do not apply, or formally defer enrollment, you forfeit future participation in the Retiree Plan.

One-Time Deferral

- **One-time Deferral Option**. You and/or your spouse are eligible to defer your enrollment in this Retiree Plan ***at any time*** on a one-time basis **with proof of other health coverage**.
- You must still elect Retiree coverage within 60 days of retirement; if you want to use the one-time, voluntary deferral option, you can do so by completing the form and providing proof of other health coverage along with the effective date of other health coverage.

Proof of other health insurance coverage must be provided when submitting your one-time deferral.

It must also be provided at the time you elect to re-enroll to show there was continuous health insurance coverage.

Please note: Proof of other health insurance coverage must include an effective date and the names of the covered individuals.

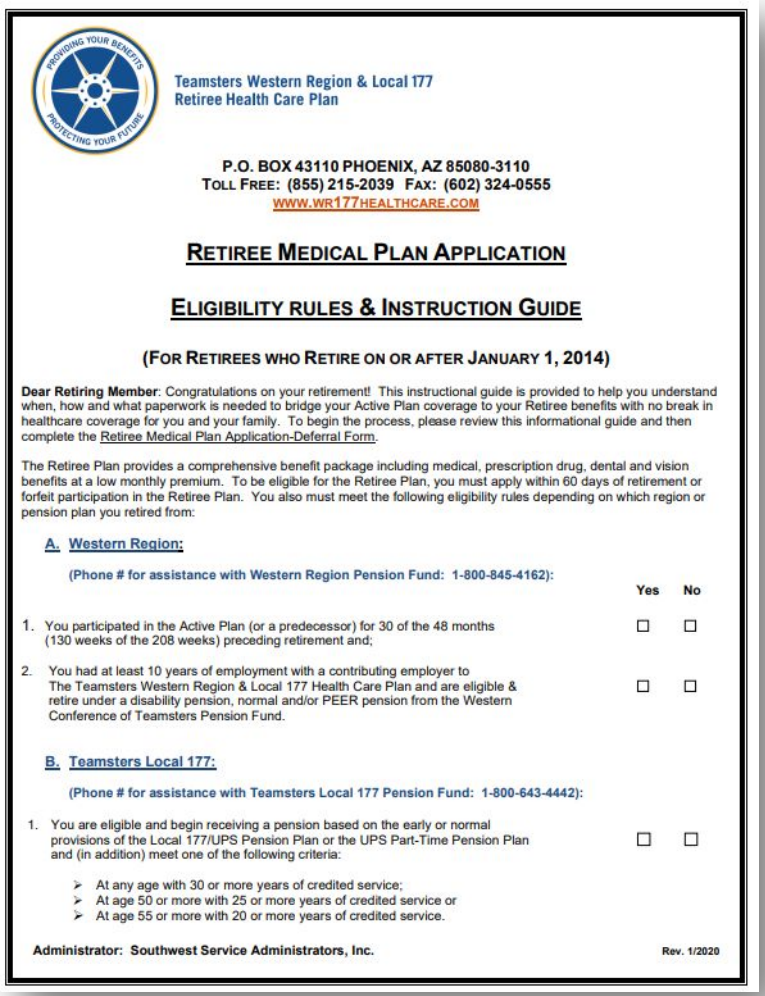
How to Apply

- Go to www.wr177healthcare.com.
- Click on ***Documents, Forms and Mailings***.
- Click on ***Retiree Plan***.
- Click on ***Forms***. Select **"TWR Retiree Medical Plan Application-Deferral Form."**
- Download and print the form, then complete it, sign it and mail it to the Fund Office. Also include the following documents:
  - A copy of your Pension Confirmation documents. NOTE: You must have applied for your pension benefits in order for your Medical Plan application to be approved.
  - If you are eligible for a Social Security Disability, attach a copy of the Social Security Award letter.
  - If you are eligible for Medicare benefits, attach a copy of your Medicare card.

Questions?

Call the Fund Office (Southwest Service Administrators, Inc.) at 855-215-2039

RETIREE HEALTH PLAN APPLICATION/DEFERRAL INSTRUCTIONS



Teamsters Western Region & Local 177
Retiree Health Care Plan

P.O. BOX 43110 PHOENIX, AZ 85080-3110
TOLL FREE: (855) 215-2039 FAX: (602) 324-0555
WWW.WR177HEALTHCARE.COM

RETIREE MEDICAL PLAN APPLICATION

ELIGIBILITY RULES & INSTRUCTION GUIDE

(FOR RETIREES WHO RETIRE ON OR AFTER JANUARY 1, 2014)

Dear Retiring Member: Congratulations on your retirement! This instructional guide is provided to help you understand when, how and what paperwork is needed to bridge your Active Plan coverage to your Retiree benefits with no break in healthcare coverage for you and your family. To begin the process, please review this informational guide and then complete the Retiree Medical Plan Application-Deferral Form.

The Retiree Plan provides a comprehensive benefit package including medical, prescription drug, dental and vision benefits at a low monthly premium. To be eligible for the Retiree Plan, you must apply within 60 days of retirement or forfeit participation in the Retiree Plan. You also must meet the following eligibility rules depending on which region or pension plan you retired from:

A. Western Region:

(Phone # for assistance with Western Region Pension Fund: 1-800-845-4162):

	Yes	No
1. You participated in the Active Plan (or a predecessor) for 30 of the 48 months (130 weeks of the 208 weeks) preceding retirement and;	☐	☐
2. You had at least 10 years of employment with a contributing employer to The Teamsters Western Region & Local 177 Health Care Plan and are eligible & retire under a disability pension, normal and/or PEER pension from the Western Conference of Teamsters Pension Fund.	☐	☐

B. Teamsters Local 177:

(Phone # for assistance with Teamsters Local 177 Pension Fund: 1-800-643-4442):

1. You are eligible and begin receiving a pension based on the early or normal provisions of the Local 177/UPS Pension Plan or the UPS Part-Time Pension Plan and (in addition) meet one of the following criteria:	☐	☐

- At any age with 30 or more years of credited service;
- At age 50 or more with 25 or more years of credited service or
- At age 55 or more with 20 or more years of credited service.

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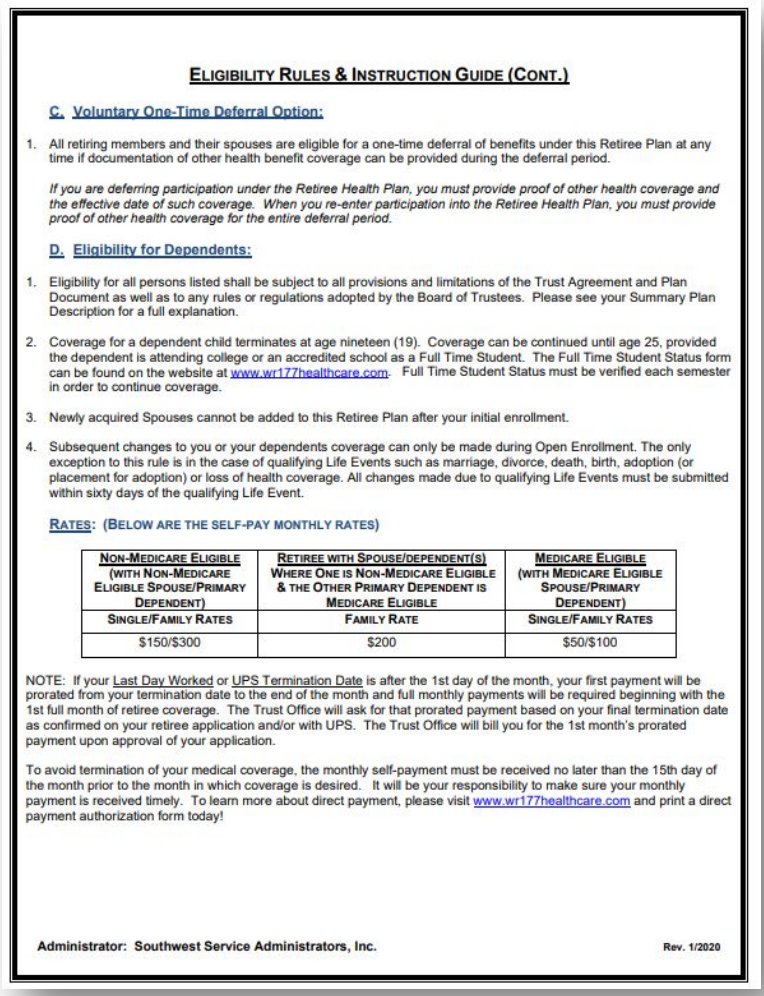

ELIGIBILITY RULES & INSTRUCTION GUIDE (CONT.)

C. Voluntary One-Time Deferral Option:

1. All retiring members and their spouses are eligible for a one-time deferral of benefits under this Retiree Plan at any time if documentation of other health benefit coverage can be provided during the deferral period.

   If you are deferring participation under the Retiree Health Plan, you must provide proof of other health coverage and the effective date of such coverage. When you re-enter participation into the Retiree Health Plan, you must provide proof of other health coverage for the entire deferral period.

D. Eligibility for Dependents:

1. Eligibility for all persons listed shall be subject to all provisions and limitations of the Trust Agreement and Plan Document as well as to any rules or regulations adopted by the Board of Trustees. Please see your Summary Plan Description for a full explanation.
2. Coverage for a dependent child terminates at age nineteen (19). Coverage can be continued until age 25, provided the dependent is attending college or an accredited school as a Full Time Student. The Full Time Student Status form can be found on the website at www.wr177healthcare.com. Full Time Student Status must be verified each semester in order to continue coverage.
3. Newly acquired Spouses cannot be added to this Retiree Plan after your initial enrollment.
4. Subsequent changes to you or your dependents coverage can only be made during Open Enrollment. The only exception to this rule is in the case of qualifying Life Events such as marriage, divorce, death, birth, adoption (or placement for adoption) or loss of health coverage. All changes made due to qualifying Life Events must be submitted within sixty days of the qualifying Life Event.

RATES: (BELOW ARE THE SELF-PAY MONTHLY RATES)

NON-MEDICARE ELIGIBLE (WITH NON-MEDICARE ELIGIBLE SPOUSE/PRIMARY DEPENDENT)	RETIREE WITH SPOUSE/DEPENDENT(S) WHERE ONE IS NON-MEDICARE ELIGIBLE & THE OTHER PRIMARY DEPENDENT IS MEDICARE ELIGIBLE	MEDICARE ELIGIBLE (WITH MEDICARE ELIGIBLE SPOUSE/PRIMARY DEPENDENT)
SINGLE/FAMILY RATES	FAMILY RATE	SINGLE/FAMILY RATES
$150/$300	$200	$50/$100

NOTE: If your Last Day Worked or UPS Termination Date is after the 1st day of the month, your first payment will be prorated from your termination date to the end of the month and full monthly payments will be required beginning with the 1st full month of retiree coverage. The Trust Office will ask for that prorated payment based on your final termination date as confirmed on your retiree application and/or with UPS. The Trust Office will bill you for the 1st month's prorated payment upon approval of your application.

To avoid termination of your medical coverage, the monthly self-payment must be received no later than the 15th day of the month prior to the month in which coverage is desired. It will be your responsibility to make sure your monthly payment is received timely. To learn more about direct payment, please visit www.wr177healthcare.com and print a direct payment authorization form today!

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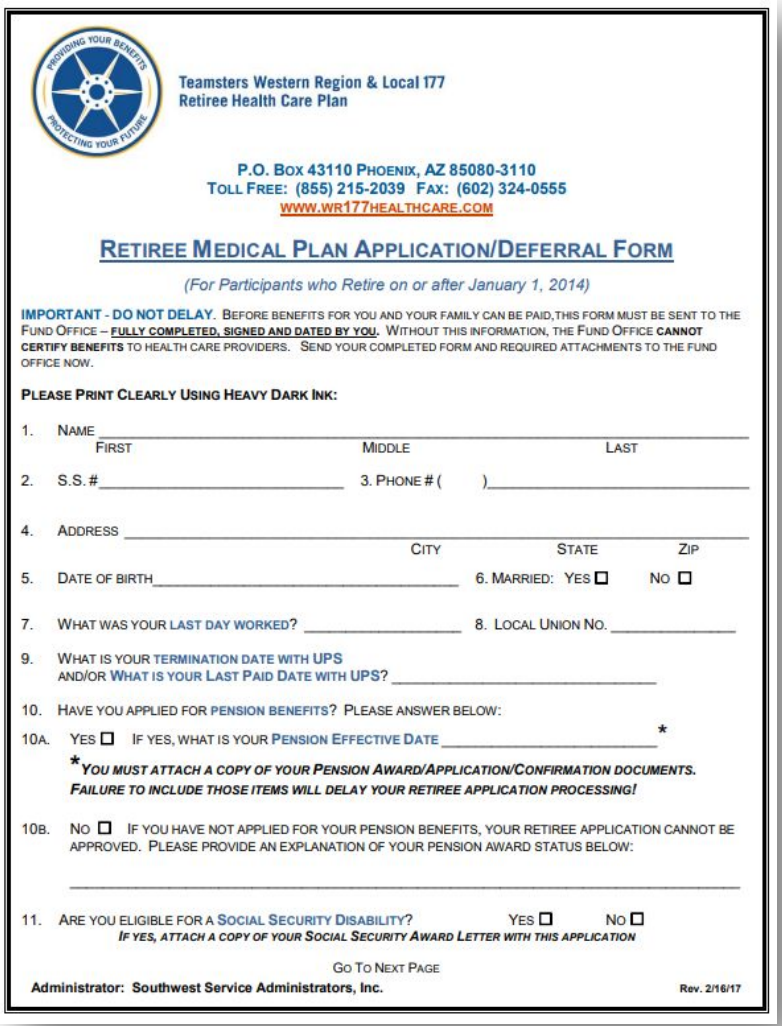
RETIREE HEALTH PLAN APPLICATION/DEFERRAL FORM



Teamsters Western Region & Local 177
Retiree Health Care Plan

P.O. Box 43110 Phoenix, AZ 85080-3110
Toll Free: (855) 215-2039 Fax: (602) 324-0555
www.wr177healthcare.com

Retiree Medical Plan Application/Deferral Form

(For Participants who Retire on or after January 1, 2014)

IMPORTANT - DO NOT DELAY. Before benefits for you and your family can be paid, this form must be sent to the Fund Office – **fully completed, signed and dated by you.** Without this information, the Fund Office **cannot certify benefits** to health care providers. Send your completed form and required attachments to the fund office now.

Please Print Clearly Using Heavy Dark Ink:

1. Name _____ (First / Middle / Last)
2. S.S.# _____ 3. Phone # ( ) _____
4. Address _____ (City / State / Zip)
5. Date of Birth _____ 6. Married: Yes ☐ No ☐
7. What was your last day worked? _____ 8. Local Union No. _____
9. What is your termination date with UPS and/or What is your Last Paid Date with UPS? _____
10. Have you applied for pension benefits? Please answer below:

10A. Yes ☐ If yes, what is your Pension Effective Date _____ *

**You must attach a copy of your Pension Award/Application/Confirmation documents. Failure to include those items will delay your retiree application processing!*

10B. No ☐ If you have not applied for your pension benefits, your retiree application cannot be approved. Please provide an explanation of your pension award status below:

_____

11. Are you eligible for a Social Security Disability? Yes ☐ No ☐
If yes, attach a copy of your Social Security Award Letter with this application

Go To Next Page

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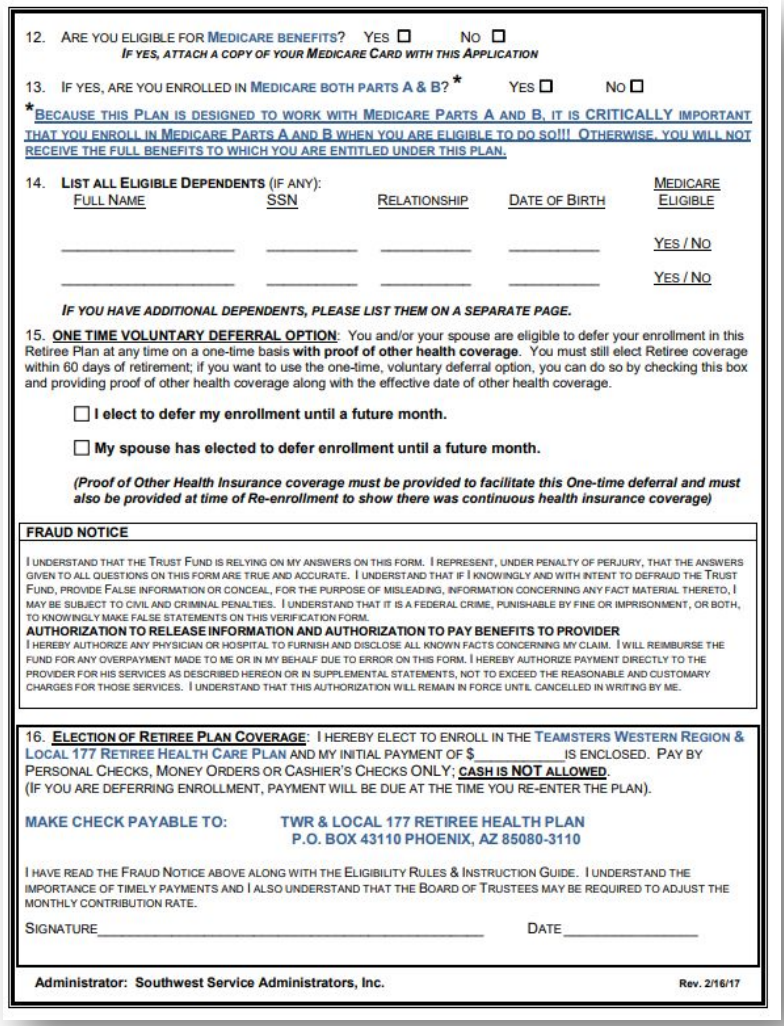


12. Are you eligible for Medicare benefits? Yes ☐ No ☐
If yes, attach a copy of your Medicare Card with this Application

13. If yes, are you enrolled in Medicare both parts A & B? * Yes ☐ No ☐

*Because this Plan is designed to work with Medicare Parts A and B, it is CRITICALLY important that you enroll in Medicare Parts A and B when you are eligible to do so!!! Otherwise, you will not receive the full benefits to which you are entitled under this plan.

14. **List all Eligible Dependents** (if any):

Full Name	SSN	Relationship	Date of Birth	Medicare Eligible
				Yes / No
				Yes / No

If you have additional dependents, please list them on a separate page.

15. **One Time Voluntary Deferral Option**: You and/or your spouse are eligible to defer your enrollment in this Retiree Plan at any time on a one-time basis **with proof of other health coverage**. You must still elect Retiree coverage within 60 days of retirement; if you want to use the one-time, voluntary deferral option, you can do so by checking this box and providing proof of other health coverage along with the effective date of other health coverage.

☐ **I elect to defer my enrollment until a future month.**

☐ **My spouse has elected to defer enrollment until a future month.**

(Proof of Other Health Insurance coverage must be provided to facilitate this One-time deferral and must also be provided at time of Re-enrollment to show there was continuous health insurance coverage)

FRAUD NOTICE

I understand that the Trust Fund is relying on my answers on this form. I represent, under penalty of perjury, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Trust Fund, provide false information or conceal, for the purpose of misleading, information concerning any fact material thereto, I may be subject to civil and criminal penalties. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this verification form.

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize any physician or hospital to furnish and disclose all known facts concerning my claim. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I hereby authorize payment directly to the provider for his services as described hereon or in supplemental statements, not to exceed the reasonable and customary charges for those services. I understand that this authorization will remain in force until cancelled in writing by me.

16. **Election of Retiree Plan Coverage**: I hereby elect to enroll in the Teamsters Western Region & Local 177 Retiree Health Care Plan and my initial payment of $_____ is enclosed. Pay by Personal Checks, Money Orders or Cashier's Checks ONLY; **cash is NOT allowed**.
(If you are deferring enrollment, payment will be due at the time you re-enter the plan).

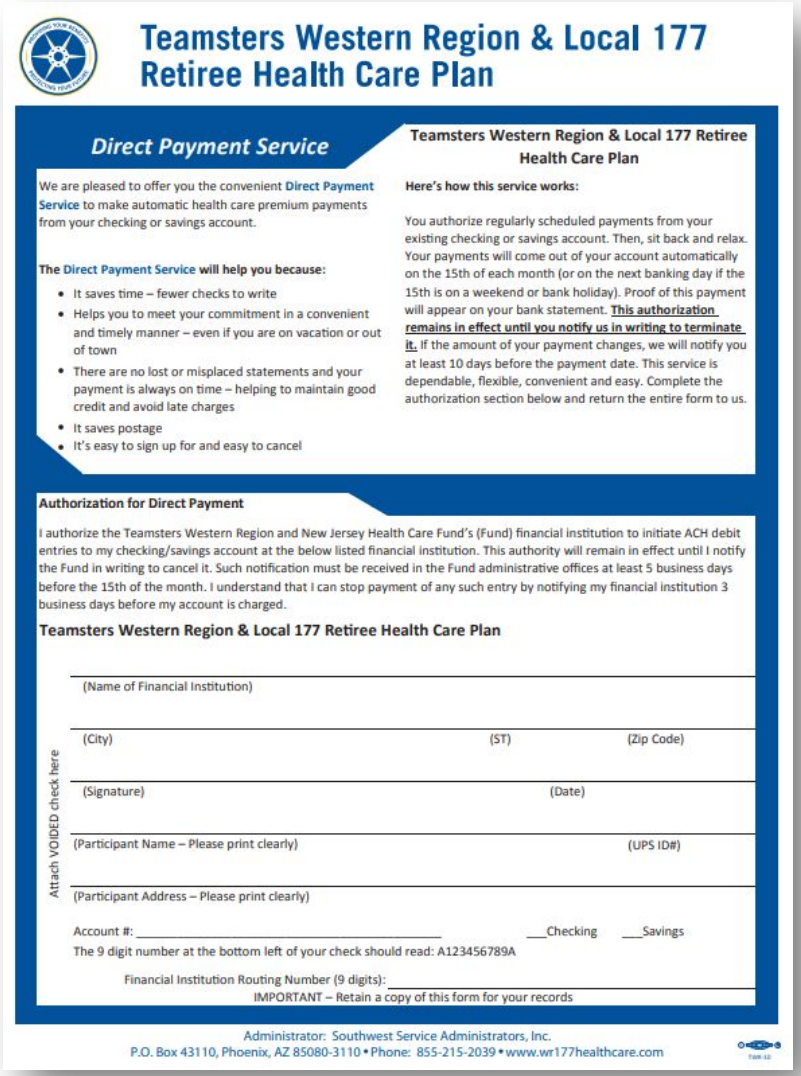
MAKE CHECK PAYABLE TO: TWR & LOCAL 177 RETIREE HEALTH PLAN
P.O. BOX 43110 PHOENIX, AZ 85080-3110

I have read the Fraud Notice above along with the Eligibility Rules & Instruction Guide. I understand the importance of timely payments and I also understand that the Board of Trustees may be required to adjust the monthly contribution rate.

Signature _____ Date _____

Administrator: Southwest Service Administrators, Inc. Rev. 2/16/17

RETIREE DIRECT PAYMENT FORM



Teamsters Western Region & Local 177 Retiree Health Care Plan

Direct Payment Service

We are pleased to offer you the convenient **Direct Payment Service** to make automatic health care premium payments from your checking or savings account.

The Direct Payment Service will help you because:

- It saves time – fewer checks to write
- Helps you to meet your commitment in a convenient and timely manner – even if you are on vacation or out of town
- There are no lost or misplaced statements and your payment is always on time – helping to maintain good credit and avoid late charges
- It saves postage
- It's easy to sign up for and easy to cancel

Teamsters Western Region & Local 177 Retiree Health Care Plan

Here's how this service works:

You authorize regularly scheduled payments from your existing checking or savings account. Then, sit back and relax. Your payments will come out of your account automatically on the 15th of each month (or on the next banking day if the 15th is on a weekend or bank holiday). Proof of this payment will appear on your bank statement. **This authorization remains in effect until you notify us in writing to terminate it.** If the amount of your payment changes, we will notify you at least 10 days before the payment date. This service is dependable, flexible, convenient and easy. Complete the authorization section below and return the entire form to us.

Authorization for Direct Payment

I authorize the Teamsters Western Region and New Jersey Health Care Fund's (Fund) financial institution to initiate ACH debit entries to my checking/savings account at the below listed financial institution. This authority will remain in effect until I notify the Fund in writing to cancel it. Such notification must be received in the Fund administrative offices at least 5 business days before the 15th of the month. I understand that I can stop payment of any such entry by notifying my financial institution 3 business days before my account is charged.

Teamsters Western Region & Local 177 Retiree Health Care Plan

(Name of Financial Institution)

(City) (ST) (Zip Code)

(Signature) (Date)

(Participant Name – Please print clearly) (UPS ID#)

(Participant Address – Please print clearly)

Account #: ___Checking ___Savings

The 9 digit number at the bottom left of your check should read: A123456789A

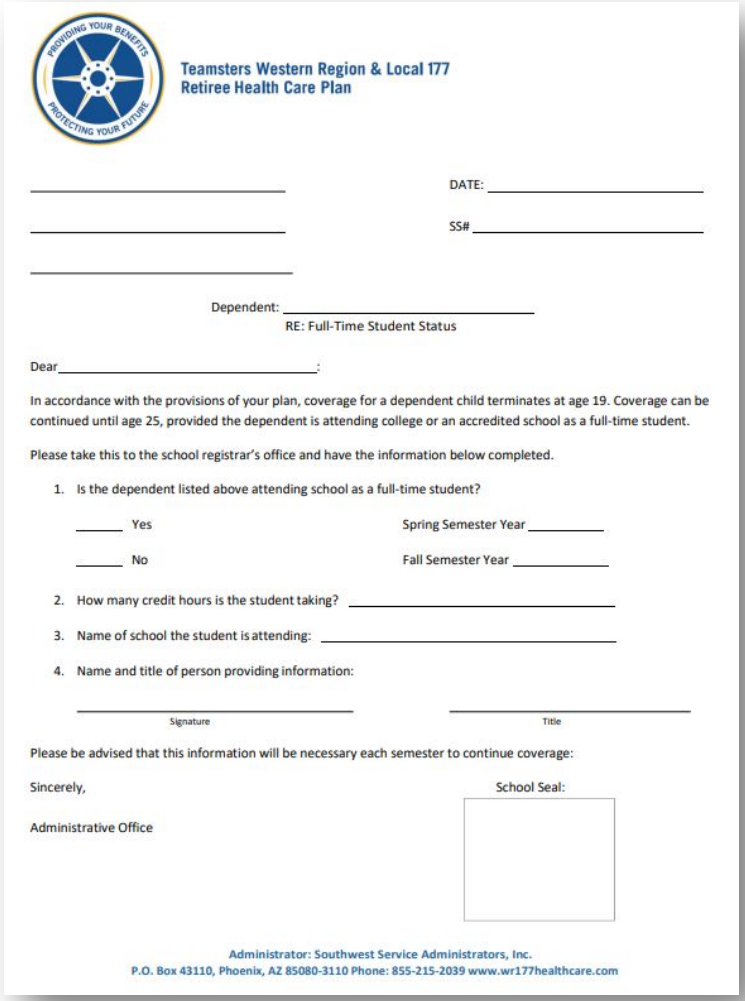
Financial Institution Routing Number (9 digits):

IMPORTANT – Retain a copy of this form for your records

Attach VOIDED check here

Administrator: Southwest Service Administrators, Inc.
P.O. Box 43110, Phoenix, AZ 85080-3110 • Phone: 855-215-2039 • www.wr177healthcare.com

FULL-TIME STUDENT FORM FOR DEPENDENT AGE 19-25



Teamsters Western Region & Local 177
Retiree Health Care Plan

_____ DATE: _____

_____ SS# _____

_____

Dependent: _____
RE: Full-Time Student Status

Dear_____:

In accordance with the provisions of your plan, coverage for a dependent child terminates at age 19. Coverage can be continued until age 25, provided the dependent is attending college or an accredited school as a full-time student.

Please take this to the school registrar's office and have the information below completed.

1. Is the dependent listed above attending school as a full-time student?

   _____ Yes Spring Semester Year _____

   _____ No Fall Semester Year _____

2. How many credit hours is the student taking? _____
3. Name of school the student is attending: _____
4. Name and title of person providing information:

   _____ (Signature) _____ (Title)

Please be advised that this information will be necessary each semester to continue coverage:

Sincerely,

Administrative Office

School Seal:

Administrator: Southwest Service Administrators, Inc.
P.O. Box 43110, Phoenix, AZ 85080-3110 Phone: 855-215-2039 www.wr177healthcare.com

Medical Coverage for Post-65 Retirees & Medicare-Eligible Participants

- Your coverage under the Teamsters Western Region & Local 177 Retiree Health Care Plan will continue when you become eligible for Medicare. However, Medicare will become the primary payer for your medical expenses and the Plan will pay benefits secondary to Medicare.
- Because the Plan is designed to work with Medicare Parts A and B when you are eligible for Medicare**, YOU MUST enroll in Medicare Parts A and B (typically in the months before turning age 65).**
- Since prescription drug coverage is included in the Plan, and the coverage is considered to be creditable coverage as defined by Medicare, you do not need to enroll in Medicare Part D (prescription drug coverage).
- While the Plan is designed to coordinate with Medicare Parts A and B, it is not intended to pay all amounts that Medicare does not cover. **Benefits payable under the Plan are considered together with the benefits received from Medicare.**

Retiree Health Plan Contact Information

Benefit	Vendor	Website/Phone
Medical & Behavioral Health	Aetna BCBSAZ	www.aetna.com 800-770-6803 www.teamsters.azblue.com 844-899-4074
Prescription Drugs	CVS Caremark	www.caremark.com 855-305-3020
Dental	Aetna	www.aetna.com 877-238-6200
Vision	VSP	www.vsp.com 800-877-7195
Virtual Care Provider	Transcarent/98point6	www.98point6.com/twr 866-657-7991

Retiree Health Plan Contact Information

Administrator	Services	Phone/Website/Address
Southwest Service Administrators, Inc.	*Enrollment *Payment *Updates *Forms *Secure Portal	(855) 215-2039 www.ssatpa.com P.O. Box 43110 Phoenix, AZ 85080-3110

Questions & Answers