



GENERAL TEAMSTERS LOCAL 251

Affiliated with the International Brotherhood of Teamsters, Washington, D.C.

Attention First Student Teamsters

As part of negotiations between Teamsters Local 251 and First Student on 8 local supplemental agreements, all First Student Teamsters in Rhode Island will have access to quality healthcare through the Teamsters Local 251 Health Services & Insurance Plan (HSIP).

We are pleased to share that Trustees of HSIP have approved keeping the costs of the healthcare "Premium Plan" the same for 2027 as it has been for 2026.

We have included additional information on the Premium Plan, so you are aware of the benefits involved.

Fraternally,

Matthew Taibi
Secretary Treasurer
Principal Officer

Matthew Taibi
*Secretary-Treasurer
Principal Officer*

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General Teamsters in the entire state of Rhode Island and Southern Massachusetts including but not limited to the towns of Assonet, Fall River, Rehoboth, Seekonk, Somerset, Swansea and Westport.

Medical Benefits – At a Glance (UnitedHealthcare-Choice Plus)

Level 2	Brown Health Network	Non- Brown Health UnitedHealthcare Provider Network	Out of Network
Deductible	\$0	\$500/\$1,000 per calendar year	\$500/\$1,000 per calendar year
Out of Pocket Maximum	\$2,000/\$4,000 individual/family per calendar year	\$2,000/\$4,000 individual/family per calendar year	\$4,000/\$8,000 individual/family per calendar year
Routine Physical Exams	\$15	\$15	30% after deductible
Specialist	\$25	\$25	30% after deductible
Preventative Lab, X-Ray and Diagnostics	\$0	\$0	30% after deductible
Inpatient	\$0	10% after deductible	30% after deductible
Outpatient Surgery	\$0	10% after deductible	30% after deductible
Durable Medical	\$0	10% after deductible	30% after deductible
Urgent Care Center	\$50 copay	\$50 copay	30% after deductible
Emergency Room Care	\$100 copay	\$100 copay	\$100 copay

Health and Well-Being Programs (Bree Health and Navigator Healthcare)

Bree Health provides access to a confidential well-being program, provided at no cost to you or your eligible family members to assist with a variety of issues and personal concerns 24 hours a day, 7 days a week.

Navigator Healthcare, Inc. complements your health and wellness benefits at no additional cost to you. Examples:

- Obtain information about substance use: prevention, intervention & treatment
- Talk through experience or concerns about drug or alcohol use for yourself or your family member
- Get started with rapid access (typically within 48) to effective, in-network treatment services, appointment scheduled for you
- Receive ongoing recovery support following the start of treatment

CVS Caremark (Prescription Drug Benefits)

FILLED THROUGH A BROWN HEALTH PHARMACY

Deductible does not apply

- Generic drugs (Tier 1)
Retail: 30-day supply - 5% coinsurance w/max copay of \$3.50
Mail Order: 90-day supply - 5% coinsurance w/max of \$7.00
- Preferred brand drugs (Tier 2)
Retail: 30-day supply - 25% coinsurance w/max copay of \$12.50
Mail Order: 90-day supply - 25% coinsurance w/max of \$25.00
- Non-preferred brand drugs (Tier 3)
Retail: 30-day supply - 35% coinsurance w/max copay of \$20.00
Mail Order: 90-day supply - 35% coinsurance w/max of \$40.00
- Specialty drugs (Tier 4)
Follows the same three tier copay structure as outlined for generic, preferred brand and non-preferred brand medications.
- Long term medications must be filled as a 90-day supply
Medications greater than a 30-day supply can only be filled through a CVS Pharmacy or Lifespan Pharmacy. You may get up to a 90-day supply for a 60-day co-payment.

FILLED THROUGH A NON-BROWN HEALTH PHARMACY

Deductible does not apply

- Generic drugs (Tier 1)
Retail: 30-day supply – 20% coinsurance w/max copay of \$50.00
Mail Order: 90-day supply - 20% coinsurance w/max of \$100.00
- Preferred brand drugs (Tier 2)
Retail: 30-day supply - 25% coinsurance w/max copay of \$50.00
Mail Order: 90-day supply - 25% coinsurance w/max of \$100.00
- Non-preferred brand drugs (Tier 3)
Retail: 30-day supply - 35% coinsurance w/max copay of \$50.00
Mail Order: 90-day supply - 35% coinsurance w/max of \$100.00
- Specialty drugs (Tier 4)
Follows the same three tier copay structure as outlined for generic, preferred brand and non-preferred brand medications.
- Long term medications must be filled as a 90-day supply
Medications greater than a 30-day supply can only be filled through a CVS Pharmacy or Lifespan Pharmacy. You may get up to a 90-day supply for a 60-day co-payment.

OUT OF NETWORK RETAIL: NOT COVERED.

Delta Dental (Dental Benefit)

The annual maximum is \$2,500.00 per member per calendar year. The annual deductible is \$0.00.

All covered Diagnostic and Preventative procedures will not be deducted from the calendar year maximum.

The maximum lifetime cap: Unlimited

A pretreatment estimate is recommended for more costly procedures.

Please contact Customer Service at (401) 752-6100

Effective 1/1/2024 – Delta Dental will pay 100% up to the allowance for the participating specialty dentist consultation.

Plan pays 100%: Member Coinsurance 0%	Plan pays 80%: Member coinsurance 20%
Oral exam—2oral exam per calendaryearperformed by a general dentist	Crowns over natural teeth, build ups, post and cores
Cleaning – Twice per calendar year	Bridges and crowns over implants
FluorideTreatment—for childrenunder age 19twice per calendar year	Partial and complete dentures
Bitewing x-rays – one set per calendar year	Osseous (bone) surgery once quadrant every 36 months
Complete x-ray series or panoramic film once every 36 months. A panoramic film is a benefit for individuals ages 6 and older	Gingivectomies once per site every 36 months
Single x-rays are required	Soft tissues graft once per site every 60 months
Sealants for children under age 16, once every24 months on unrestored permanent molars	Crown lengthening once per site every 60 months
Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year	Guided tissue regeneration and bone replacement graft once per site every 24 months
Amalgam (silver) and composite (white) fillings	Occlusal guards
Space maintainers once every 60 months for lost deciduous (baby) teeth	Occlusal adjustments once every 12 months
Extractions and other routine oral surgery when not covered by a patient's medical plan	
General anesthesiaorintravenous (I.V.) sedation for certain complex surgical procedures	Implant Rider: Plan pays 50%; Member Coinsurance 50%
Root canal therapy on permanent teeth – one procedure per tooth per lifetime.	Implants and related services subject to a separate \$3500 lifetime maximum
Repairs to existing partial or complete dentures once per calendar year	
Recementing crownsorbridges onceevery60 months	Orthodontics: Plan pays 50%; Member Coinsurance 50%
Rebasing or relining of partial or complete dentures once every 60 months	Elective braces and related services for all covered members. Subject to a lifetime maximum. No preapproval required
Periodontal maintenance following active therapy – two per year	Lifetime maximum (orthodontics only) is \$2,500.00
Root planing and scaling once per quadrant Every 24 months	

EyeMed (Eye Care Benefits)

Your benefits include:

Effective January 1, 2025, an eye exam once every calendar year and complete pair of glasses, or two pair of glasses, or a pair of glasses and contacts.

Please visit the EyeMed website at eyemed.com for the full Summary of benefits and participating eye doctors located under the INSIGHT network.

Vision Care Services

Exam Services
Retinal Imaging

In-Network Member Cost

\$0 Copay
Up to \$39

Frame

Frame at a Plus Provider
allowance Frame
allowance

\$0 copay; 20% balance over \$230
\$0 copay; 20% off balance over \$180

Standard Plastic Lenses

Single, Bifocal, Trifocal
Standard Progressive
Standard Anti Reflective
Polycarbonate- Standard
Tint

\$0 copay
\$0 copay
\$0 copay
\$0 copay
\$0 copay

Contact Lenses*

Contacts – Conventional allowance
Contacts - Disposable allowance
\$0 copay: 15% off balance over \$200
\$0 copay: 100% of allowance over \$200

Lasik Services

One-time \$1,000 (\$500 per eye) Lifetime allowance

OUT OF NETWORK SERVICES: NOT COVERED

251 HSIP Premium Plan (medical, prescription drug, dental, vision, EAP):

Monthly Total Costs

		Employee	EE+ Spouse	EE+Ch	Family
Effective	1/1/2027	\$911.94	\$1,869.48	\$1,823.88	\$2,781.42
Effective	1/1/2028	Cost increase not to exceed 6%			
Effective	1/1/2029	Cost increase not to exceed 6%			
Effective	1/1/2030	Cost increase not to exceed 6%			

Examples of First Student Employee Cost Sharing for 2027:

7.5% Employee weekly share at 36 weeks - Employee Only \$22.80; Ee + Spouse \$46.74; Ee + Ch \$45.60; Family \$69.54

10% Employee weekly share at 52 weeks - Employee Only \$21.04; Ee + Spouse \$43.41; Ee + Ch \$42.09; Family \$64.19

20% Employee weekly share at 52 weeks - Employee Only \$42.09; Ee + Spouse \$86.28; Ee + Ch \$84.18; Family \$128.37

35% Employee weekly share at 52 weeks - Employee Only \$73.66; Ee + Spouse \$151.00; Ee + Ch \$147.31; Family \$224.65

35% Employee weekly share at 36 weeks - Employee Only \$106.39; Ee + Spouse \$218.11; Ee + Ch \$212.79; Family \$324.50