ACTIVE DENTAL/VISION PROGRAM SUMMARY PLAN DESCRIPTION

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

A Letter from the Board of Trustees

Dear Member:

The Board of Trustees is pleased to provide you with this Summary Plan Description (SPD)…a current description of your TeamstersCare Dental and Vision Program. The benefits described in this booklet, as authorized by the Trustees and administered by our TeamstersCare staff, are benefits that you have earned—and continue to earn—over the course of your working years.

The Trustees are committed to providing you and your eligible family members with high-quality dental and vision benefits. The Board of Trustees is the Plan Sponsor and Plan Administrator of the benefits according to the terms of this SPD and the Agreement and Declaration of Trust of the Teamsters Union 25 Health Services & Insurance Plan.

You and your family have access to local TeamstersCare in-house dental services at our Charlestown, Chelmsford, and Stoughton facilities in supportive surroundings and at the hands of our own dedicated TeamstersCare healthcare professionals. You also have access to the Dental Blue Freedom network, a national network of dentists providing care at a discounted fee. The Program also provides an extremely generous comprehensive vision benefit through Davis Vision, including routine eye care services and eyewear products. You and your spouse also have access to our yearly flu clinics.

Please read this booklet carefully and make certain your family understands how they can use the SPD to find important information.

If you have questions on any aspect of your benefits, visit us in person at any of our facilities, view our website at **www.teamsterscare.com**, or contact TeamstersCare through Charlestown Member Services at the following numbers:

local: 617-241-9220, ext 2,
toll free in MA: 800-442-9939, ext 2,
toll free outside MA: 800-225-6135, ext 2.

Remember: We're here for you—no question you or a dependent may have is too basic to ask—or too much trouble for us to answer.

Sincerely,

Board of Trustees

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Introduction

The Teamsters Union 25 Health Services & Insurance Plan, more commonly called TeamstersCare, offers you and your family quality dental and vision coverage. If you're an eligible TeamstersCare member, you, your spouse and your dependent children have the following benefits:

- TeamstersCare in-house dental care
- Dental Blue Freedom network dental care
- Davis Vision network routine vision care
- Flu clinic coverage (member and spouse only)

Certain Collective Bargaining Agreements (CBAs) may provide different benefits. If you are covered by one of these Agreements, you'll receive additional information specific to your benefits.

The Patient Protection and Affordable Care Act

In March 2010, Congress passed and the President signed into law the Affordable Care Act. As a result of the Act, TeamstersCare is required to provide you with certain health care coverages and information.

Grandfathered Plan under the Affordable Care Act

TeamstersCare believes that our plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered plan means that TeamstersCare may not include certain consumer protections of the Act that apply to other plans. For example, we are not required to follow the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, such as the elimination of lifetime dollar limits for benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause the plan to change status can be directed to the TeamstersCare Executive Director, at 617-241-9220 ext. 244. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Eligibility

Member Eligibility

You become eligible for TeamstersCare dental and vision benefits in one of two ways:

- you begin working for an employer who is already participating with Teamsters Local 25 (or some other participating Local or organization) and who is contributing to Teamsters Union 25 Health Services & Insurance Plan (TeamstersCare) for dental and vision benefits—in this case, you become an active participant as soon as you fulfill the eligibility requirements and enroll in the Program

or

- you are already working for an employer who begins participating with Teamsters Local 25 (or some other participating Local or organization) and begins contributing to TeamstersCare for dental and vision benefits—in this case, you become an active participant when your employer has made the required contributions and you fulfill the eligibility requirements and enroll in the Program.

- The eligibility requirements vary, depending upon the Collective Bargaining Agreement through which you have coverage.

How You First Become Eligible

You become eligible for benefits, once you're covered by a contract requiring contributions on your behalf, in one of two ways, depending on the terms of the Collective Bargaining Agreement.

1. You have to work, and your employer must have remitted contributions for a total of 400 or more hours over a period of any three consecutive months. When you reach 400 hours during that three-month period, you become eligible to enroll in the Plan for the first of the following month. After you enroll, coverage for you and your eligible dependents begins on the first day of the next month following the accumulation of the 400 hours.

Example: If you work and your employer contributes on your behalf 110 hours for March, 200 hours for April and 160 hours for May, you are eligible to enroll for benefits beginning June 1.

2. You work for a participating employer who makes the required monthly contribution to TeamstersCare on your behalf, whether employer or employee

paid. Eligibility starts the first day of the month for which we receive the contribution.

Example: If you work in June and your employer submits contributions on your behalf for that month, you are eligible to enroll for benefits beginning June 1.

Important Note*: In this SPD, anytime the word "work" is used as it relates to eligibility, it means credited with required contributions according to the Collective Bargaining Agreement or by law. In this context, "required contributions" means contributions owed to the Fund for those hours – or part of hours – for which wages are paid or due, figured to the nearest quarter hour, as well as hours for paid vacation, paid holiday, and other hours for which pay is due or received by the member.*

How You Remain Eligible

After you've become eligible for the first time (regardless of what month your eligibility starts), you remain eligible in one of two ways depending on the terms of your Collective Bargaining Agreement.

1. If your eligibility is based on the 400 hour rule, you remain eligible through the next January 31, or April 30, or July 31, or October 31—whichever date comes first. These dates are called **eligibility review dates** and they are used to determine your continuing eligibility.

Important Note*: Under a special Plan provision, the first time you become eligible you're entitled to no less than three months coverage. Thus, if the period between the day you first become eligible to enroll and the following eligibility review date is less than three months, your eligibility automatically extends to the next following eligibility review date.*

On each eligibility review date, we look at the number of hours you've worked during a fixed three-month period. So long as you worked 400 or more hours during that fixed three-month eligibility determination period, and your employer has made the required contributions on your behalf, you continue to be eligible, from the review date on, for the next three months going forward. Here's how the eligibility cycle works:

Your eligibility is reviewed on:	If you worked at least 400 hours during the preceding:	You continue to be eligible for the next:
January 31	Oct., Nov. & Dec.	February, March, & April
April 30	Jan., Feb. & March	May, June, & July
July 31	April, May & June	August, Sept., & Oct.
October 31	July, Aug. & Sept.	November, Dec., & Jan.

2. If your eligibility is based on a required monthly contribution, you remain eligible each month so long as you continue to work for your employer and your employer makes the required monthly contribution.

How to Reinstate Lost Eligibility under the 400 Hour Rule

If you are covered under the 400 hour rule, and for some reason you do not meet the eligibility requirements, then you lose TeamstersCare coverage. In order to reinstate your eligibility, you must work at least 400 hours in a rolling three-month reinstatement period that occurs either before or within 12 months after you've lost coverage. Once you're ineligible for more than 12 months, you have to gain coverage just as though you were a new member. (See How You First Become Eligible on page 6.)

When reinstating, you can work your 400 hours before or after the date on which your eligibility ends. The number of months you lose coverage, and the number of months of eligibility you earn when you reinstate, both depend on the relationship between the date you lose eligibility and the three-month rolling reinstatement period when you work your 400 hours. Once you become ineligible, you must always lose at least one month of coverage before you can regain eligibility.

Reinstatement Example. If you lose your eligibility on April 30th, regardless of how or when you reinstate, you must lose coverage for at least the month of May. The earliest three-month period you can use to reinstate is February/March/April. So, on April 30th, you look back at those three months; if you reached 400 hours during that period, you lose coverage for May, but reinstate as of June 1st.

However, if you don't make your 400 hours in February/March/April, you then "roll" forward to the next three-month period, March/April/May. On May 31st, you look back on that period to see if you've worked 400 or more hours. If yes, your eligibility reinstates on June 1st; if no, then you "roll" forward to the next three-month period,

April/May/June...and so on, from one three-month period to the next, until you work 400 or more hours in any consecutive three-month period.

Dependent Eligibility

When Your Dependents Are Eligible

Once your own eligibility begins, your dependents also become eligible for the TeamstersCare Dental and Vision Benefit Program.

Important Note*:* For purposes of TeamstersCare eligibility, once your dependent is enrolled, and so long as your dependent meets the Plan's definition of "eligible dependent," you cannot terminate coverage for that dependent.

"Eligible dependents" include:

- your current spouse, or an ex-spouse who was covered by the Plan when you divorced, or an ex-spouse who is an eligible and enrolled dependent when a new employer begins contributing to the Plan, in cases where:
    - you have a divorce decree requiring you to cover your ex-spouse, or
    - you have a divorce decree requiring you to cover your ex-spouse and you decline coverage for your current spouse (in order to maintain coverage for your ex-spouse) and your current spouse agrees in writing to waive coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other coverage
- your children, up to the last day of the month the dependent reaches age 26
- your unmarried children who are incapable of self-care because of a physical or mental disability, provided they first became disabled before turning 26 and were covered by the Plan at that time. For further details, contact Member Services at 617-241-9220, ext. 2.

Important Notes*:*

- ✓ New members working for a regular contributing employer cannot cover an ex-spouse if the member was divorced or legally separated before joining the Plan.
- ✓ Members who lose coverage for one year or longer and reinstate coverage are considered new members. An ex-spouse of a new member is not considered an eligible dependent.
- ✓ If you maintain coverage for your ex-spouse and your ex-spouse remarries, your ex-spouse is no longer an eligible dependent and coverage for your ex-spouse ends.
- ✓ You cannot cover a spouse and an ex-spouse at the same time.

Defining "Eligible Children"

"Eligible children" include your natural children; dependent children of your eligible dependent; legally adopted children; children placed with you for adoption; stepchildren (note that if you divorce, your former stepchildren are no longer considered eligible dependents); children for whom the member has been appointed legal guardian; foster children. Eligibility ends with the termination of guardianship or foster care.

TeamstersCare also provides coverage to a member's children named under a Qualified Medical Child Support Order, provided a copy of this order is filed with Teamsters Union 25 Health Services & Insurance Plan, 16 Sever Street, Charlestown, MA 02129-1305. Call Charlestown Member Services at 617-241-9220 ext. 2 for a copy of TeamstersCare's procedures regarding Qualified Medical Child Support Orders.

Continuing TeamstersCare Coverage

Continuing TeamstersCare Coverage under COBRA

In certain cases where you or your dependents would otherwise lose dental and vision benefits, you may be able to continue dental and vision coverage under the Federal law known as COBRA (see the information beginning on page 23 for details on COBRA coverage).

Dependent Coverage when Your Eligibility Ends

Your dependents lose coverage at the same time your own eligibility ends. Individual dependents can also lose coverage if they no longer meet the definition of an eligible dependent; however they may be able to continue dental and vision coverage through COBRA (see page 25 for details on COBRA coverage for dependents).

Family Coverage in Case of Your Death

If you die while covered by the TeamstersCare Dental Vision Program ***and you're covered under the 400 hour rule,*** TeamstersCare will continue to provide your family with dental and vision benefits for up to three months beyond the benefit coverage period when your dependents would otherwise lose eligibility. After three months, your family will have the option of continuing coverage under COBRA.

If you die while covered by the TeamstersCare Dental Vision Program and you're covered by a CBA that requires a monthly contribution, TeamstersCare will continue to provide your family with dental and vision benefits for one month beyond the month you would normally lose coverage. Your family will then have the option of continuing

coverage under COBRA. When extending benefits under any of these options, certain conditions may apply. For more information, call Charlestown Member Services at 617-241-9220 ext. 2.

Continuing Coverage for Your Spouse after Legal Separation or Divorce

In the event of divorce or legal separation, a court might order you to provide healthcare coverage for your former spouse and eligible dependents. In certain cases, TeamstersCare may extend the same dental and vision coverage to which your ex-spouse had been previously entitled. To be eligible, your ex-spouse must have been covered by the Plan at the time of your divorce. You will need to provide Charlestown Member Services with the effective date of the divorce and documentation of the court order within 31 days of your divorce becoming final.

If coverage is extended, but your ex-spouse subsequently remarries, then the extended coverage ends on the day before the remarriage. You, as the member, are responsible for notifying TeamstersCare within 31 days of this change in family status. If you remarry, you may elect to continue coverage for your ex-spouse—instead of your new spouse—provided your new spouse agrees in writing to waive all coverage from Teamsters Union 25 Health Services & Insurance Plan and provides proof of other dental and vision coverage. You cannot cover a spouse and an ex-spouse at the same time.

If, upon divorce, you are not required to provide coverage for your ex-spouse, TeamstersCare coverage ends and he/she may be eligible to purchase temporary extended dental and vision coverage under COBRA for up to 36 months (see page 25 for details of COBRA coverage for dependents).

You, as the member, are responsible for notifying an ex-spouse of all benefit information including benefit changes, reinstatements, providing ID cards, etc. The Plan is responsible for notifying an ex-spouse of COBRA coverage upon termination of benefits.

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

Coverage on Returning from Military Duty

If you return to your job within 90 days of authorized military duty, your TeamstersCare coverage is reinstated immediately, provided:

- you were eligible for benefits at the time you went on duty
- you work at least one hour for a contributing employer after returning from military duty
- your employer provides TeamstersCare with documentation that you have returned to work, and
- you provide proof of military service listing your discharge date

If you are covered under the 400-hour eligibility rule, your reinstated coverage continues for the remainder of the eligibility determination period during which you were reinstated through the subsequent benefit coverage period, according to the following schedule:

Eligibility Determination Period	Benefit Coverage Period
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

For example, if you return to work on August 20, and work at least one hour, then coverage for you and your eligible dependents begins on August 20 and continues through January 31.

While you are in the military, you and your dependents have the right to elect continued benefit coverage under COBRA for up to 24 months (see page 23 for details on COBRA coverage).

Coverage through Medicaid and the Children's Health Insurance Program (CHIP)

If you are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored

plan. Go to the TeamstersCare website for a list by state with contact information for the Medicaid and CHIP Offices.

How to Enroll in TeamstersCare Benefits

Information You Must Provide to Enroll in TeamstersCare Benefits

Once you are eligible, in order to enroll in TeamstersCare benefits, we must have complete, accurate, and up-to-date information for you and your eligible dependents. You're responsible for providing this information and for keeping the information updated.

Once you have met the eligibility requirements, and your employer has made the required contributions, Charlestown Member Services will send you an Enrollment Package. You must complete the Enrollment Form and return it to Charlestown Member Services with the required documentation (i.e. marriage license and birth certificate for each dependent child) within 31 days of receiving the package.

Important Note: TeamstersCare cannot activate your benefits, which means you and your family will not have access to TeamstersCare coverage, until we have received a complete and accurate Enrollment Form and corresponding documentation. If the Enrollment Form is not received within 31 days from when we send the package, eligibility for benefits will be activated on the first day of the month that the Enrollment Form and documentation is received.

Change in Family Status Notification

A change in family status is any event that affects the records we currently have on file for you and your dependents. This includes, but is not limited to, the following:

- a change in your address or the address of an eligible dependent
- marriage, divorce or legal separation, or the mandate of a court order
- adding a new dependent by: birth, adoption, or placement for adoption; marriage; the mandate of a Qualified Medical Child Support Order (QMCSO)
- death of an eligible participant
- loss of dependent eligibility
- coverage for you and/or any of your dependents under any group benefit plans other than TeamstersCare

Important Note: If you have a change in family status you—or someone acting on your behalf—must notify Charlestown Member Services by telephone or in writing **within 31 days of the change** (see page 48 for contact information). If you fail to do so, TeamstersCare cannot ensure continuous or timely coverage of any claims incurred beyond that 31-day time period.

TeamstersCare may require that you submit certain changes in writing or proof of your change in family status, at the time you notify us of the change. TeamstersCare manages all eligibility and enrollment issues. Anytime you provide us with eligibility-related information, we'll notify all the benefit vendors on your behalf.

Suspension of Benefits

There are certain instances where, although you may be otherwise eligible for TeamstersCare benefits, your benefits and those of your dependents could be suspended until such time as the situation causing your suspension is remedied. A member's suspension could result from:

- not submitting an Enrollment Form when TeamstersCare requires you to
- enrolling an ineligible dependent
- committing fraud or misrepresenting information to TeamstersCare
- a check for a COBRA payment, or TeamsterShare Payment is returned from your bank as unpaid
- not responding to a divorce recertification request
- not repaying claims incurred by an ineligible dependent (for example after a divorce)

A member, who is suspended on the date a qualifying event is sustained, will not be extended COBRA coverage.

TeamstersCare Benefits

Dental Benefits

Under the TeamstersCare Plan, you and your eligible dependents have three basic options when you need dental care.

Option #1: TeamstersCare Dentists. You can use our in-house Charlestown, Chelmsford, or Stoughton, MA facilities for your dental treatment—with no claim forms to file. Preventive visits are available at no cost to you. You make a TeamsterShare Payment of $5 for filling visits and $10 for denture, root canal, and extraction visits.

Option #2: Dentists in one of the Dental Blue Freedom networks. TeamstersCare has an agreement with Blue Cross Blue Shield of MA (BCBSMA) which provides three networks of "private" dentists who accept discounted fees. When you use one of the Dental Blue Freedom networks, you have to pay part of the cost, and the dentist will file the claim.

Option #3: Non-Network Dentists. You can use any "private" dentist you like. Again, you'll have to share the cost (generally, higher than Dental Blue Freedom network dentist costs), and you may be required to file a claim.

Option #1: TeamstersCare Dentists

You and your family have a convenient option for basic dental services: complete access to our TeamstersCare Dental Offices in Charlestown, Chelmsford, and Stoughton. When you go to a TeamstersCare Dental Office, you pay nothing for preventive care visits. You make a TeamsterShare Payment of $5 for filling visits and $10 for denture, root canal, and extraction visits.

TeamstersCare Dental Offices are staffed by licensed dentists, hygienists, and dental assistants. Some of our TeamstersCare dentists are on staff at Tufts and Boston University Dental Schools.

Services Provided at TeamstersCare In-house Dental Offices

The following general services are available at our three TeamstersCare Dental Offices:

- dental examinations and x-rays (preventive)
- fluoride treatment (preventive)
- cleaning and scaling (preventive)
- sealants
- fillings—amalgam and composite (silver and white)
- root canals—limited to front six upper and front six lower teeth
- simple extractions—limited to loose primary or permanent teeth
- dentures—full or partial, no more frequently than once every five years
- denture repair and reline
- mouthguards
- certain space maintainers
- second opinions
- emergency care during office hours—so long as the evaluations and treatment of dental problems are within the scope of the services provided at our TeamstersCare Dental Offices

Making Appointments

Dental Office Hours

- Monday through Thursday—Open 8 a.m., some evening appointments until 8 p.m.
- Friday and Saturday—8 a.m. to 4 p.m.

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

Charlestown

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

Chelmsford

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

Stoughton

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

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

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

Option #2: Dental Blue Freedom Network Dentists

TeamstersCare has contracted with Blue Cross Blue Shield of Massachusetts (BCBSMA) for coverage through a group of private dentists who provide both routine and specialty services and, at the same time, helps you save money on dental care.

TeamstersCare participates in Dental Blue Freedom which gives you access to Dental Blue PPO, Dental Blue, and Dentemax which is a national network. You have great flexibility in your choice of dentists; however, you will receive the largest discount if you choose a Dental Blue PPO dentist. The larger network, Dental Blue, offers access to over 90% of all practicing dentists in MA, however your share of the costs will generally be higher than with a PPO dentist. If you're away from home, you also have access to the Dentemax national network of BCBS dental providers.

Your Dental Blue Freedom ID Card

You will receive a Dental Blue Freedom ID card that you must show whenever you visit a dentist—whether or not that dentist is in one of the Dental Blue Freedom networks.

- For a Dental Blue Freedom dentist—the card ensures that you will receive the TeamstersCare discount
- For any other private, non-network dentist—the card provides information the dentist will need for accurate billing

To determine whether a particular dentist is in one of the Dental Blue Freedom networks, go to www.bluecrossma.com or call BCBSMA's Customer Service at 1-800-241-0803. Have your Dental Blue Freedom ID card available so you can refer to it for TeamstersCare group information.

Option #3: Non-Network Dentists

You do not have to go to a dentist in one of the Dental Blue Freedom networks. You have the flexibility to go to any dentist you wish. However, when you go outside one of the Dental Blue Freedom networks, you'll generally have to pay an even larger share of the cost, and you may be involved in some paperwork.

Costs for Dental Blue Freedom Network and Non-Network Dental Services

Dental Blue Freedom Benefits Fee Schedule

TeamstersCare has a pre-set Dental Fee Schedule of the dollar amounts it will pay for covered dental procedures when those procedures are performed by any dentist other than our own in-house practitioners in Charlestown, Chelmsford, and Stoughton.

The TeamstersCare Dental Fee Schedule is subject to change. To view the current fee schedule, go to **www.teamsterscare.com** or contact Charlestown Member Services.

Your Share

For any given procedure, the Plan always pays the same amount, regardless of whether you go to a Dental Blue Freedom network dentist or a non-network dentist. In either case, you pay a portion of the bill. The difference is, most likely the Dental Blue Freedom dentist will charge you less to begin with, because of our TeamstersCare contract with BCBSMA. Thus, the balance you pay to a Dental Blue Freedom network dentist—after TeamstersCare makes its pre-set contribution—will almost certainly be smaller than the portion you'd have to pay to a non-network dentist.

Deductibles and Calendar Year Maximum

Except for diagnostic and preventive services, any dental treatment you receive outside of the TeamstersCare Dental Offices is subject to a $50 per person/$100 per family calendar year deductible. Also, there is a calendar year maximum benefit of $2,500 per person.

Orthodontics

Orthodontic Services are covered at 50% of cost, up to a $2,000 lifetime maximum per person. Coverage is available for the member, spouse, and eligible dependents.

Total Health Solutions

Your dental coverage through Dental Blue Freedom includes enhanced benefits through Total Health Solutions. This is a program which identifies patients with certain health conditions that are impacted by dental care and provides them with additional benefits. These conditions include coronary artery disease, diabetes, oral cancer and pregnancy.

Dental Treatment in the Hospital

If you have a serious medical condition and therefore can't be treated in a dental office, your dentist might recommend that you be treated in a hospital. Generally, the TeamstersCare dental benefit will share the cost of the dental services you receive in the hospital—but not any related medical costs. For medical coverage and claims, you'll need to follow whatever procedures are appropriate for the medical insurance plan in which you and your family are enrolled.

Dental Expenses Not Covered

TeamstersCare does not provide dental benefits for the following:

- services or supplies in a hospital operated by the U.S. government or a government agency
- services under any government law or program to which you might be entitled
- treatment of a work-related condition
- cosmetic dental services—unless the procedure is required because of an accident that happens while you are covered by TeamstersCare, subject to the rules of the Plan
- treatment by anyone other than a licensed dentist or physician—or a qualified dental technician working under a dentist's or physician's direction
- training or supplies used for dental care education
- treatment for temporomandibular joint (TMJ) syndrome—except for specific medical conditions verified by x-ray or other diagnostic tests
- experimental procedures
- charges exceeding amounts listed in the TeamstersCare Dental Benefits Fee Schedule
- charges you or your family members are not obligated to pay
- services provided for injuries that result from a war, declared or undeclared
- charges for missed appointments

Pre-Treatment Dental Estimates

BCBSMA can help you estimate your share of dental expenses before you're actually treated.

If your dentist recommends extensive treatment, the dentist can submit a Pre-treatment Estimate Form to BCBSMA for an estimate of your share of the cost. Getting the estimate is voluntary, but it can help avoid surprises about the amount you're responsible for. You can then plan the treatment and manage your expenses accordingly.

Filing a Dental Claim

When you use a TeamstersCare in-house dental facility, you file no claim forms.

BCBSMA handles any claim submitted by Dental Blue Freedom network dentists as well as any non-network claims.

If you have to submit a dental claim yourself, the appropriate forms should be available at your dentist's office. Otherwise, call BCBSMA Member Service directly, at 1-800-241-0803 to obtain a form.

Important Note: You must submit dental claims within 12 months of the date when the service was provided.

Dental claim forms for in-network and non-network services should be addressed to:
Blue Cross Blue Shield of MA
P.O. Box 986030
Boston, MA 02298

If you have any questions about how a claim should be handled, call BCBSMA at 1-800-241-0803.

Coordinating with Other Dental Plans

If you or a dependent has other dental coverage—such as through your spouse's plan—any benefits you receive from that other plan will be coordinated with your TeamstersCare benefit. Taken together, total payments from all plans cannot be more than 100% of the charges (see page 34 for details on Coordination of Benefits).

Vision Benefit

TeamstersCare has contracted with Davis Vision to provide eye care benefits for you and your family that help protect your eyesight—while also managing the cost of caring for your vision needs.

Davis Vision Network

Davis Vision is a national network with participating providers throughout the United States. Under TeamstersCare's Plan, you can visit any Davis Vision provider for a broad range of eye care services and supplies—generally, at no cost to you.

For a list of participating providers, call Davis Vision at 1-800-999-5431, visit **www.davisvision.com**, or contact Charlestown Member Services.

Your TeamstersCare Vision Benefit

Participating Davis Vision professionals can provide you and your family members with the following services and supplies:

- routine eye examinations, at no cost to you
  - for you and your spouse – one exam each, every 24 months
  - for eligible children – one exam every 12 months

and either

- eyeglasses, at no cost to you, from the Plan's eyewear selection

or

- contact lenses, for a $25 copay

Important Note: When choosing either glasses or contacts, you must make your full selection at the time you have your authorized eye examination. If you go to a provider who only provides an exam because the office does not dispense eyeglasses, you must order glasses through another provider within 30 days of your vision exam.

Eyewear You Can Select

The Plan offers a wide assortment of eyeglasses, all with a one-year warranty. You can select:

- at no cost to you — eyeglasses; a wide variety of frames and lenses; prescription sunglasses; safety glasses (for members only),

or

- for a $25 copay
  - standard, daily-wear soft contact lenses

    or
  - a three-month supply of disposable lenses with a cleaning kit

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

The TeamstersCare eyewear options differ for your and your dependents:

- As a ***Plan member***, you can receive as many as ***three pairs of eyeglasses*** during any consecutive 24-month period. You must select all three pairs at the time of your examination. The following options apply to the combinations you can select:
  - One of your three pairs can be non-prescription (plano)
  - You may choose safety glasses
  - You may choose sunglasses
  - Prescription lenses—two of your three pairs can have any combination of special lenses (e.g., invisible bifocals; trifocals; photo-gray tinting; premium anti-reflective coating; transitional, progressive, or intermediate vision lenses). However, if you select prescription lenses for all three pairs, then at least one pair must be single vision lenses.
- Your ***eligible spouse*** can receive ***two pairs of eyeglasses***, during any consecutive 24-month period, in any combination of lenses. Both pairs must be prescription and both must be selected at the time of the eye examination.
- Your dependent children can receive one pair of prescription eyeglasses every 12 months. The eyeglasses must be selected at the time of the eye examination.

If You Choose Contact Lenses

You can select either contact lenses or eyeglasses, but not both. If you choose contact lenses, you then have to wait 24 months before you can select eyeglasses from the Plan. Also, once the contact lenses are fitted, you cannot exchange them for eyeglasses.

The Plan does not cover extra contact lenses, replacements, or contact lens insurance. However, if you select disposable lenses, you may purchase additional lenses for a discount from Davis Vision. For information on this option, visit **www.davisvisioncontacts.com.**

If you select contact lenses, you have to pay a $25 copay directly to the Davis Vision provider. If you need a type of contact lens not available from the Plan, TeamstersCare will pay for your eye exam, but you must pay all other costs.

Laser Vision Correction

TeamstersCare has negotiated a 25% discount from the usual and customary fee if you choose to have laser vision correction surgery at a participating Davis Vision facility.

Important Note: Aside from the Davis Vision discount, laser vision correction surgery is not a covered benefit.

Making an Appointment

To schedule an appointment, contact a local Davis Vision provider's office directly. To locate a Davis Vision provider, you may call 1-800-999-5431 or visit **www.davisvision.com.**

When you call, the Davis Vision provider will help determine whether you're eligible for an examination and eyeglasses under the Plan. In addition, you can check your eligibility for services by calling 1-800-999-5431 or by logging into your account **www.davisvision.com**.

You should have received a list of participating Davis Vision providers in your enrollment package. However, if you need another copy or more information about your vision benefits, call Charlestown Member Services or go to our website at **www.teamsterscare.com**.

Important Note: **For routine vision care, it's important to remember that equipment, services, and supplies are covered through the TeamstersCare Plan only at a Davis Vision network provider.**

Administration

Continuing Your Health Coverage under COBRA

If you lose eligibility for the TeamstersCare Dental and Vision Program for reasons called "qualifying events," you can continue your health coverage under a Federal law called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).

Under COBRA, you can maintain your current TeamstersCare dental vision coverage. You will have to pay the full cost of your benefits, plus up to a 2% administration fee, through monthly premiums.

When you become eligible for COBRA, you can extend coverage for yourself, your spouse, and your dependents who were covered at the time of the qualifying event. In addition, during the period when you are covered by COBRA, the following persons are also automatically eligible:

- any newborn or adopted child added to your family
- any child placed with you (the member) for adoption
- a spouse who becomes your dependent if you marry

To enroll these new dependents, you must notify Charlestown Member Services within 31 days of the birth, adoption, or marriage. Your newborn or adopted child(ren) or child(ren) placed with you for adoption during your period of COBRA continuation coverage are considered qualified beneficiaries and have independent rights to elect and change elections under COBRA. However, your new spouse or other dependents added during your COBRA continuation coverage period are not qualified beneficiaries and do not have independent COBRA rights.

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

The Period for Making Your Decision About COBRA Coverage

To continue coverage under COBRA, you have to submit a TeamstersCare Benefit Continuation Form. You or your eligible dependents must complete and return the Form to TeamstersCare sometime within 60 days of the later of two dates:

- either the date you receive notice of your rights to continue coverage under the Plan

or

- the date your TeamstersCare coverage ends

Cost of Continued Coverage

You and your covered dependents will be required to pay up to 102% of the full group cost for your continued coverage. However, this cost may be increased to 150% for a qualified 11-month extension of coverage due to disability. See page 25 for details on Continuing Coverage While Disabled, or call Charlestown Member Services (see page 48 for contact information).

Important Note: COBRA rates change from time to time, depending on the general cost of healthcare, cost variations among different providers, and the Federal government's decisions about COBRA benefits and administration. If COBRA costs or benefits change in the future, we will let you know ahead of time. For current coverage costs, contact Charlestown Member Services.

Your first COBRA payment is due no later than 45 days after the date you (or a dependent) elect continued coverage. After you've paid this first premium, you need to continue making payments by the first of every month. However, each month, you have a 30-day grace period in which to pay your premium.

Important Note: During a premium-payment "grace period" your eligibility cannot be reactivated nor your claims processed until the premium has been paid.

The first COBRA payment is retroactive to the date of your "qualifying event," loss of coverage, or the date you became ineligible because of insufficient hours.

Qualifying Events

Continuing Coverage for up to 18 Months

You and your spouse and/or dependents can continue dental vision benefits for up to 18 months if the Fund receives timely notice that you are losing coverage for any one of these "qualifying events":

- you don't work enough hours in an eligibility determination period

  or

- you retire and subsequently lose coverage

  or

- your job ends for any other reason (other than gross misconduct)

Continuing COBRA Coverage While Disabled

Under certain circumstances, you and your dependents may be able to extend dental and vision benefits for a total of 29 months—11 additional months beyond the original 18 months of COBRA continuation coverage. This occurs when you or a covered dependent:

- is disabled under Title II or XVI of the Social Security Act when you stop working for any of the "qualifying events" named above

  or

- becomes disabled under Title II or XVI of the Social Security Act anytime during the first 60 days of your initial 18-month COBRA coverage period

Sometime during your first 18 months of continued coverage, you need to obtain a special determination letter from the Social Security Administration (SSA) saying that you or your dependent was disabled under Title II or XVI of the Social Security Act when your qualifying event occurred, or during the first 60 days of your initial 18-month COBRA coverage period.

You must then notify TeamstersCare in writing and provide a copy of the SSA disability determination letter sometime during this same 18-month continuation period and no later than 60 days after you've received your disability determination from the SSA.

Termination of coverage during the 29-month period will occur if you or your dependent is found by the SSA to be no longer disabled. Termination will occur on the first day of the month beginning more than 30 days after the date of the final determination. All reasons for termination that apply to the initial 18 months will also apply for any additional months of coverage.

Continuing Dependent Coverage for up to 36 Months

In some cases, your dependents can have coverage extended for a total of up to 36 months. Dependents may be eligible for 36 months of continued benefits if they would otherwise be losing coverage for any one of the following "qualifying events":

- your death
- your divorce or legal separation
- your entitlement to Medicare
- your dependent no longer meets the Plan's definition of "eligible dependent"

This 36-month continuation period begins at different times, depending on the particular "qualifying event," as follows:

- Your death. Remember, depending upon your Collective Bargaining Agreement, that your dependents may continue to receive TeamstersCare dental and vision benefits after your death for one month or up to three months beyond the benefits coverage period when they were last eligible (see page 10 for details on "What happens to coverage when a member dies"). At the end of that three-month period, your dependents can then elect to continue their extended coverage, under COBRA, for an additional 36 months.
- Your divorce or legal separation. The 36-month continuation period begins with the date of divorce or separation.
- Your entitlement to Medicare. The 36-month continuation period begins when you become entitled to Medicare and your dependents would otherwise lose coverage.
- Your dependent no longer meets the plan's definition of "eligible dependent." The 36-month continuation period starts on the date when the dependent no longer qualifies as a dependent under the Plan.

COBRA and Medicare

You are eligible to continue dental vision benefits under COBRA if you become entitled to Medicare and then have a COBRA qualifying event. However, you are not eligible to continue your dental vision benefits if you have a qualifying event and then for the first time become entitled to Medicare after you have elected COBRA continuation coverage. Your dependents can still continue their own dental vision benefits, provided they have not become covered under some other group health plan. For dependents, this continuation extends for one of two periods, depending on which of the two provides coverage longer:

- either 36 months from the date you first became covered by Medicare,
- or for 18 months following the date of the qualifying event

Example: Suppose you're an active Plan member and you turn 65 (and so become covered by Medicare) on March 1, 2018. One year later, as of February 28, 2019, you retire and then subsequently lose Plan eligibility—which is a "qualifying event." You are generally eligible for 18 months of COBRA continuation coverage. Your dependents would be eligible to continue benefit coverage until:

  - either 36 months following the date you first became covered by Medicare—which would extend coverage until March 1, 2021
  - or 18 months following the date of the qualifying event—which would extend coverage through August 31, 2020

In this example, since the 36-month continuation gives your dependents the longer of the two coverages, it's this 36-month period that applies.

More Than One Qualifying Event for Your Dependents

If your dependents become eligible to continue their coverage under more than one "qualifying event," they may be able to extend their benefits for up to a combined total of 36 months. This total 36-month period begins on the date of the first "qualifying event."

Example: Suppose you lose eligibility under one of the "qualifying events" that provides your dependent child with 18 months' continuation coverage—your retirement would be an example.

Sometime during that initial 18-month continuation coverage period, your dependent child no longer meets the plan's definition of "dependent." For example, you reach the end of the month when your dependent turns age 26. This is a second "qualifying event." Your child may then be eligible for additional extended coverage up to a total of 36 months. This 36-month period would begin on the date of the first qualifying event – your retirement.

Notification of a Qualifying Event

TeamstersCare's responsibility. If you qualify for COBRA and the Fund receives timely notice from your employer that you are losing coverage because you failed to work the required number of hours, or under certain Collective Bargaining Agreements that you no longer work for that employer, then TeamstersCare will take the first action—by notifying you and/or your covered dependents of COBRA eligibility.

Your responsibility. For certain other "qualifying events," you or a family member must take the first step in the process by notifying TeamstersCare of the event. You, your spouse, or a dependent is responsible for this notification if eligibility would otherwise end because:

- you become divorced or legally separated
- your dependent child no longer meets the Plan's definition of "eligible dependent"

For these events, you or your family member must notify TeamstersCare in writing within 60 days of the later of two dates:

- either the date of the "qualifying event"
- or the date TeamstersCare coverage ends

If you do not notify TeamstersCare within 60 days of the event, coverage will terminate.

When COBRA Continued Coverage Ends

If your coverage has been continued for any of the reasons described above, including disability, the extended coverage will end when any one of the following happens:

- You or your dependent fails to pay the cost of continued coverage before the end of a grace period extension (see page 24 for details on Cost of Continued Coverage).
- You become covered under some other employer's group dental and vision plan (either as an employee or dependent) after you have already elected COBRA continuation coverage.
- You first become entitled to Medicare—relative to your own coverage—after you elect COBRA coverage.
- Your spouse or dependent becomes entitled to Medicare—relative to his or her own coverage—after he/she elects COBRA coverage.
- Coverage was continued due to a disability and then the SSA determines you or your dependent is no longer disabled. In this case, termination will occur on the first day of the month beginning more than 30 days after the date of the final determination.
- Continued coverage reaches the 18-, 29-, or 36-month limit—whichever applies.

If You Have Questions about COBRA

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Additional information is also available through EBSA's website at www.dol.gov/ebsa.

EBSA Headquarters:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue N.W.
Washington, D.C. 20210 1-202-219-8776

EBSA Boston Regional Office:

Employee Benefits Security Administration
Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203 617-565-9600 or Toll free: 1-866-444-EBSA (3272)

Your Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that helps protect the continuity of health benefits coverage. HIPAA:

- limits exclusions for pre-existing medical conditions
- credits prior health coverage in the form of certificates
- prohibits discrimination in enrollment or in premiums charged, based on health-related factors
- guarantees renewability of health insurance coverage in the group insurance markets
- preserves the states' role in regulating health insurance

HIPAA helps individuals who lose coverage under one health plan get coverage under another plan, in cases where that second plan may have "pre-existing condition" exclusions. HIPAA requires the "second plan" to reduce the length of its pre-existing exclusion period by the amount of time the individual was covered under the previous plan.

Since our TeamstersCare Plan does not have "pre-existing condition" limitations, participants who lose TeamstersCare eligibility and are looking for new coverage may encounter this problem for the first time. HIPAA entitles individuals to get a "certificate" from their previous plan that documents the length of their prior health coverage. This certificate can then be used to reduce whatever pre-existing condition exclusions might be imposed by the new plan. This HIPAA certification requirement applies only when you or your dependent(s) lose eligibility for TeamstersCare health benefits.

For members who lose eligibility, TeamstersCare will issue a certificate—reflecting the single most recent period of continuous coverage—under the following circumstances:

automatically

- when certification is required under HIPAA
- when an individual who is losing eligibility under the Plan is not entitled to COBRA
- when an individual has been covered by COBRA, but then COBRA coverage ends—this is true even when the individual may have previously received a certificate verifying earlier, pre-COBRA coverage under TeamstersCare

upon request

- before losing coverage or within 24 months of losing coverage

If you need such a certificate, call Charlestown Member Services (see page 48 for contact information).

Privacy & Notice of TeamstersCare Privacy Policies

TeamstersCare is required by law to maintain the privacy of your protected health information (PHI) and to provide you notice of TeamstersCare's legal duties and privacy practices with respect to this health information. PHI includes information which identifies you, and relates to your past, present or future physical or mental health condition, the provision of health care to you, or the payment for that care.

If you have questions about any part of this Notice, or if you want more information about our privacy practices, please contact the TeamstersCare Privacy Official at 16 Sever Street, Charlestown, MA 02129, or you may call 617-241-9220.

How TeamstersCare May Use or Disclose Your Protected Health Information

The following categories describe the ways that TeamstersCare may use and disclose your protected health information. We have not listed every use or disclosure that might be included in a given category. However, all the ways we are permitted to use and disclose information fall within one of these categories.

Treatment. Information obtained by a TeamstersCare provider, for example a dentist, may be disclosed to other healthcare providers who are part of your healthcare team in order to provide you with the best course of treatment.

Payment. We may use or disclose PHI about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, the "payment" category may include determining whether TeamstersCare covers a particular treatment.

Health Care Operations. We may use and disclose PHI about you to carry out necessary insurance-related activities. Such activities could include underwriting, premium rating and other activities relating to plan coverage; conducting or arranging for medical review, legal services, and audit services; and business planning, management, and general administration.

Required by Law. We will disclose your PHI when required to do so by federal, state or local laws. For example, we may disclose your PHI to the U.S. Department of Health and Human Services upon their request if they wish to determine whether we are in compliance with federal privacy laws.

Public Health. As required by law, we may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities. We may disclose your PHI to health agencies, as authorized by law, during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding, such as a lawsuit, in response to a subpoena.

Law Enforcement. As required by law, we may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person; complying with a valid court order or subpoena; and for other law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI to coroners, medical examiners, and funeral directors. For example, this may be needed in order to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. Consistent with applicable law, we may disclose your PHI to organizations involved in procuring, banking, or transplanting organs and tissues.

Public Safety. We may disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security. We may disclose your PHI to authorized federal officials for military intelligence and national security purposes as authorized by law.

Correctional Institutions. We may disclose your PHI to a correctional institution, if you are an inmate, as necessary for your health.

Workers' Compensation. We may disclose your PHI as necessary to comply with Workers' Compensation or similar laws.

Marketing. We may contact you to give you information about health-related benefits and services that might interest you.

Disclosures to Trustees. If you appeal a claim to the TeamstersCare Board of Trustees, we may disclose limited PHI necessary for the purpose of administering plan benefits.

When TeamstersCare May Not Use or Disclose Your Protected Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your protected health information without written authorization from you. If you do authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose PHI about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

Right to Inspect and Copy. You have the right to inspect and copy PHI about you in TeamstersCare records that may be used to make decisions about your plan benefits. To inspect or copy such information, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. We may deny your request to inspect or copy in certain limited circumstances. In such cases we will provide you with an explanation for the denial.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. TeamstersCare may not be able to comply with all requests. If you would like to make a request for restrictions, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129.

Right to Request Confidential Communications. You have the right to receive your PHI through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. TeamstersCare may not be able to comply with all requests.

Right to Request Amendment. You have the right to request that TeamstersCare amend your PHI when you believe the information is incorrect or incomplete. We are not required to change your PHI and if your request is denied, we will provide you with information about our denial and how you can appeal the denial. To request an amendment, you must make your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. You must also provide a reason for your request.

Right to Accounting of Disclosures. You have the right to receive a list or "accounting of disclosures" of your PHI made by us, except that we do not have to account for

disclosures made for purposes of treatment, payment or health care operations, disclosures made to you or others involved in your care, or disclosures that you authorize. To request this accounting of disclosures, you must submit your request in writing to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Upon your request, TeamstersCare will provide you with one list per 12-month period free of charge. We may charge you for additional lists.

Right to Paper Copy. You have the right to receive a paper copy of this Notice of TeamstersCare Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. You may also obtain a copy of this Notice at our website, **www.teamsterscare.com.**

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the TeamstersCare Privacy Official, at 16 Sever Street, Charlestown, MA 02129 or you may call 617-241-9220.

Changes to this Notice of Privacy Practices

TeamstersCare reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all protected health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, TeamstersCare is required by law to comply with the current version of this Notice.

For More Information or to Report a Problem

If you have questions about this Notice of Privacy Practices, or about how we handle your PHI, you may contact the TeamstersCare Privacy Official, 16 Sever Street, Charlestown, MA 02129. If you believe your privacy rights have been violated, you can file a complaint with the TeamstersCare Privacy Official. All complaints to TeamstersCare must be submitted in writing and submitted within 60 days of the alleged violation. TeamstersCare will not retaliate against you in any way for filing a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C. 20201. The Secretary may be reached by phone at 1-202-690-7000.

Coordination of Benefits

If you or a family member has—or acquires—dental coverage under some other group benefits plan (for example, your spouse's employer medical plan), then any benefits you receive from that other plan will be "coordinated" with your TeamstersCare coverage.

It's extremely important to understand this concept called "Coordination of Benefits" or "COB." COB provisions are routinely included in group plans. They're designed to provide Plan participants the fullest allowable coverage, while avoiding benefit over-payment.

Important Note: Under COB, TeamstersCare will make certain your expenses are properly paid, but we also need to ensure that the total payments you're eligible to receive, from all your coverages combined, do not exceed 100% of the charges you're billed. By "coordinating" our own Plan with other health coverages, we create efficiencies that will often result in full coverage for you—with lower out-of-pocket costs.

Basically, COB provisions help determine the order in which multiple parties are responsible for reimbursement in the event of a claim. To prevent a covered person from being caught in the middle of a dispute between two plans, and to provide a consistent method of deciding which plan pays first, TeamstersCare uses the National Association of Insurance Commissioners' (NAIC) guidelines to help determine the general order of benefit payment.

General COB Guidelines

In general terms, the Plan follows certain guidelines in determining whether TeamstersCare is the "primary" or "secondary" payer. In the following description, if a plan is described as "primary," it means that plan pays first. "Secondary" means that plan pays second.

Generally, benefits are determined so that if you are covered by:

- two plans from two different jobs, the plan that has covered you the longer is primary
- a plan that covers you as an active employee, that plan is primary to a plan that covers you as a retired employee
- a TeamstersCare Plan, and also by a spouse's employer plan, the spouse's plan is primary for your spouse's coverage, secondary for your coverage

- two plans and only one plan has (and abides by) COB provisions, then the plan that does not have (or does not abide by) COB provisions is primary, and the plan with the COB provision is secondary

In cases where you are covered by COBRA as a former TeamstersCare participant, but you also have coverage under some other health benefits plan (for example, another employer's plan or your spouse's employer plan), that other plan—and not the COBRA continuation—always pays first when benefits are "coordinated."

Example: Suppose John Doe's spouse has primary coverage through her employer and secondary coverage through TeamstersCare. In order for TeamstersCare to pay benefits as the secondary payer, all of the TeamstersCare Plan requirements must be satisfied. In this case, for example, John's spouse must submit a claim, including a copy of the Explanation of Benefits from the primary payer, to Dental Blue Freedom for TeamstersCare secondary coverage.

Important Note: TeamstersCare will communicate with Dental Blue Freedom, as appropriate, regarding coordination of benefit issues.

Coordinating Coverage for Children

If your children are covered by both TeamstersCare and your spouse's employer plan, the plans use a guideline called "the birthday rule" to determine which plan pays first for healthcare benefits provided to your children. The birthday rule says that benefits will be paid first by the plan of the parent whose birthday comes earlier in the calendar year.

Your Rights as a Plan Member Under ERISA

At a number of places in this SPD, you'll find references to "the Plan" or to "TeamstersCare." These terms refer to the benefit plan whose official name is "Teamsters Union 25 Health Services & Insurance Plan."

The Plan is administered by a Board of Trustees, according to the terms of:

- the Agreement and Declaration of Trust of the Teamsters Union 25 Health Services & Insurance Plan, and
- this Summary Plan Description (SPD)

These documents, taken together, make up the official "Plan Documents" as specified by the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has delegated certain day-to-day administrative duties to the Executive Director of the Fund.

As a participant in the Teamsters Union 25 Health Services & Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA, you're entitled to receive information about your plan and benefits. You may examine, free of charge, all the official documents related to the Plan. This includes insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor (such as detailed annual reports and Plan descriptions). These documents are available for review in the TeamstersCare Charlestown office during regular business hours.

You may obtain copies of all Plan documents—including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and a summary of any material Plan changes and updated SPD—by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

A copy of the Plan's most recent annual report (Form 5500 Series) is available at the Public Disclosure Room of the Employee Benefits Security Administration. By law, the Plan Administrator must furnish each participant with a copy of the Plan's Summary Annual Report (SAR).

Under ERISA, you may be entitled to continue group health plan coverage if you lose eligibility for certain reasons. You can continue healthcare coverage for yourself, your spouse, or your dependents if you lose coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this SPD and the documents governing the Plan for the rules that apply to your COBRA continuation coverage rights. (See page 23 for details on Continuing Your Health Care Coverage Under COBRA).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that, in cases where you have become ineligible for TeamstersCare benefits, you are entitled to receive a "certificate" verifying your previous coverage under the TeamstersCare Plan. This verification can then be used to reduce whatever pre-existing condition exclusions might be imposed by any new coverage you obtain.

For members who lose their TeamstersCare eligibility, the Plan will automatically issue a certificate—free of charge—reflecting the single most recent period of continuous coverage, under the following circumstances:

- when you lose coverage under the Plan
- when you become entitled to continue coverage under COBRA

- when your COBRA continuation coverage ceases, if you request the certificate before you lose coverage, or if you request it up to 24 months after losing coverage

Without such evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage. (See page 29 for details on Your Rights Under HIPAA).

Under ERISA, you're entitled to enforce certain rights. No one—including your employer, your union, or any other person—can fire you or otherwise discriminate against you in order to prevent you from obtaining a Plan benefit or exercising your ERISA rights.

If Plan fiduciaries misuse the Plan's money, or if you're discriminated against for exercising your rights, you can ask for help from the U.S. Department of Labor or file suit in a Federal court. If you sue successfully, the court can order the person you've sued to pay court costs and your legal fees. If you lose your suit, the court can order you to pay costs, plus certain fees, if, for example, it finds your claim is frivolous.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you can file suit in a Federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you believe you've been improperly denied a Plan benefit, in full or in part, you have a right, within certain time schedules, to:

- know why this was done
- obtain copies (without charge) of documents relating to the decision, and
- appeal any denial

If you have a claim for benefits that is denied or ignored, in full or in part, you can file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for operating a benefit Plan. These persons are called "fiduciaries." Plan fiduciaries are obligated to operate a Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be disqualified and required to make good any losses they have caused the Plan.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor, or you can file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Help With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA).

EBSA Headquarters:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-202-219-8776
Toll free: 1-866-444-EBSA (3272)

EBSA Boston Regional Office:

Employee Benefits Security Administration
Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203
617- 565-9600

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Information About Teamsters Union 25 HS&IP

Plan Sponsor/Plan Administrator/Named Fiduciary

The Teamsters Union 25 Health Services & Insurance Plan is a collectively bargained employee health and welfare benefits plan, administered by a Board of Trustees that includes an equal number of union representatives and employer representatives. The Trustees serve as the "Named Fiduciary" under ERISA.

The address and telephone number for the Board of Trustees is:

Board of Trustees
Teamsters Union 25 Health Services & Insurance Plan
16 Sever Street Charlestown, MA 02129
Telephone: 617-241-9220

The Board of Trustees

Designated by Teamsters Union Local 25:

Sean M. O'Brien, Co-Chair
President/Principal Officer
Teamsters Union Local 25
16 Sever Street
Charlestown, MA 02129

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

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

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

Designated by the Employers:

Tom J. Ventura, Co-Chair
Yellow Transportation, Inc.
10990 Roe Avenue
Overland Park, KS 66211

Michael Rico
UPS East Region
643 West 43rd St
New York, NY 10036

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

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

Plan Year

The Plan year for the Teamsters Union 25 Health Services & Insurance Plan is September 1 through August 31.

Employer and Plan Identification Numbers

The Board of Trustees' employer identification number is 04-6374631. The Plan number for all programs is 501.

Plan Contributions

Employers contribute to the Plan according to the terms of their individual Collective Bargaining Agreements or Standard Participation Agreements.

The Collective Bargaining Agreements require contributions to the Plan at fixed rates. The rates may be applied to the number of hours for which an employee who is covered by an Agreement receives or is due pay, in most cases up to a maximum of 40 hours per week, dependent upon the Collective Bargaining Agreement.

If you make a request in writing, TeamstersCare will provide you with a copy of your relevant collective bargaining agreement (CBA) and information as to whether a particular employer is contributing on your behalf under the bargaining agreement.

Benefit Payment

TeamstersCare dental and vision benefit payments are provided from Plan assets and are not guaranteed under a policy of insurance. These assets are accumulated under the provisions of the collective bargaining and trust agreements.

Eligibility for Benefits

See the information beginning on page 6 for detailed information on:

- benefit eligibility
- disqualification, ineligibility, denial, suspension, loss, or reinstatement of benefits

Financial Information

The Plan's assets are held in a trust fund for the exclusive purpose of providing benefits to covered participants and paying reasonable administrative expenses. Assets and reserves are invested with financial institutions in certificates of deposit, common stocks, bonds and other asset classes—all of which are authorized, approved, and administered by the Board of Trustees.

Agent for Service of Legal Process

If for any reason you wish to seek legal action, you may serve legal process upon the Plan Administrator, at the following address:

Board of Trustees
Teamsters Union 25 Health Services & Insurance Plan
16 Sever Street
Charlestown, MA 02129
Telephone: 617-241-9220

Plan Authority

The Board of Trustees has the right to administer the Plan at its sole discretion. This includes the right to make binding and conclusive determinations regarding:

- who is eligible for benefits
- the amount of benefits payable
- the meaning and applicability of Plan provisions

Similarly, the Board of Trustees reserves the right to amend, modify, reduce, or discontinue all or part of the Plan, according to the terms of the Plan and Trust Agreement, by appropriate action, including:

- changing any amounts contributed to the cost of providing benefits
- changing the level of benefits provided
- changing the class or classes of individuals eligible for benefits
- terminating the Plan in its entirety or with respect to any covered class or classes

Only the Plan Trustees may interpret Plan provisions, including: determining eligibility for benefits and the right to participate in the Plan; how hours are credited; eligibility for any benefit; discontinuing benefits; status as a covered or non-covered employee; benefit levels; and interpreting the rules with respect to a particular claim or application.

No one is authorized to speak on behalf of, or to commit the Trustees on, any Plan-related matter, without the expressed authority of the Trustees. This includes local union officers, business agents, local union employees, employers or employer representatives, TeamstersCare office personnel, consultants, or attorneys.

Claims and Appeals

Under certain circumstances, you may need to file a benefit claim. A claim is any request for a Plan benefit, made by a claimant or by a representative of the claimant that complies with the Plan's reasonable procedure for making benefit claims.

Submitting a Claim

Claims procedures vary somewhat, depending on the benefit involved. If you intend to submit a claim, first check the appropriate section of this SPD and refer to page 43 for some useful definitions. If you need further information, call Charlestown Member Services (see page 48 for contact information).

Outline of Claims Procedures				
If you have a claim for:	You must submit the itemized bill within this amount of time:	In cases where a claim form is required:	Return the form to:	Comments:
Dental	12 months from the date of service	Obtain the form at your dentist's office or call BCBS Member Service	Dental Blue Freedom Plan/ BCBSMA	You're required to submit a dental claim when you use a non-network provider

Claims Filing Information		
Name	**Address**	**Telephone**
Charlestown Member Services for general claims questions	Teamsters Union 25 Health Services & Insurance Plan 16 Sever Street Charlestown, MA 02129-1309	local: 617-241-9220 in MA: 1-800-442-9939 outside MA: 1-800-225-6135
Dental Blue Freedom	BCBSMA P.O. Box 986030 Boston, MA 02298	1-800-241-0803

Claim Determinations and Appeals

Following are the procedures governing claim determinations and claim appeals. Note that there are different types of claims and each has specific rules, timeframes, and procedures associated with it. For claims and appeals of an insured benefit or other health benefits provided by an insurance company you must follow the specific procedures set forth in the underlying insurance policy.

An **"Urgent Care Claim"** is any claim for care or treatment where using the timetable for non-urgent care determination could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is being requested.

A **"Pre-Service Claim"** is any claim for a health benefit (other than an Urgent Care Claim) that, per the terms of the Plan, must be approved before care is obtained.

A **"Post-Service Claim"** is any claim for a Plan benefit that is for services already received by the claimant.

"Adverse benefit determination" – Any of the following: a denial, reduction, termination of or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Timing of Notification of Claim Determinations

The amount of time that the Plan will take in making a claim determination will be governed by the nature of the claim.

Urgent care claims – In the case of an urgent care claim, the Plan will make the benefit determination (whether adverse or not) as soon as possible but not later than 72 hours after receipt of the claim. In the case of requests for additional treatments or periods of time involving urgent care, the Plan will make the benefit determination (whether adverse or not) within 24 hours after receipt of the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service non-urgent care claims – In the case of a pre-service non-urgent care claim, the Plan will notify you of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Post-service non-urgent care claims – In the case of a post-service non-urgent care claim, the Plan will notify you of the adverse benefit determination within a reasonable period of time but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Other Type of Claims – In the case of any other claim not referenced previously, you will be notified of the status of your claim within 90 days after the Plan receives your claim. If additional time is needed to respond to your claim (due to matters beyond the control of the Plan), you will be notified before the end of the initial period and then receive a response within 90 days after the end of the original 90-day period.

Manner and Content of Notification of an Adverse Benefit Determination

You will be furnished with written or electronic notification of any adverse benefit determination. The notification will include the following information:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provision upon which the determination is based;
- If applicable, a description of any additional material or information necessary from you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- When applicable, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the

adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request;

- When applicable, if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- When applicable, in the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such a claim.

Appeal of Adverse Benefit Determinations to the TeamstersCare Board of Trustees

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the initial adverse benefit determination. To appeal insured benefits or any other health benefit provided by an insurance carrier, you must follow and have exhausted all grievance procedures under the insurance policy.

The Plan has established and maintains a procedure through which you will be afforded a full and fair review of an adverse benefit determination. That procedure:

- Provides you 180 days to appeal an adverse benefit determination following receipt of the adverse notification.
- Provides you the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.
- Provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.
- Provides that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- Provides that the health care professional engaged for purposes of consultation on the appeal shall be an individual who is neither an individual who was

consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- Provides, in the case of a claim involving urgent care, for an expedited appeal of an adverse benefit determination by which information can be submitted and transmitted orally or by facsimile or other available expeditious methods.

Timing of Notification of Benefit Determinations on Appeal to Board of Trustees

The Board of Trustees at their next regularly scheduled meeting will make a determination of an appeal. If the appeal is received less than 30 days before the scheduled meeting, the decision may be scheduled for the second meeting following receipt of the request.

Content of Adverse Benefit Determination on Appeal

The Plan's written notice of the Board of Trustee's decision will include the following:

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

The Board of Trustees Decision is Final and Binding

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

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

Final Notes

If you have questions about your benefits, or if you do not understand the Plan because you cannot speak English, contact TeamstersCare for help—or have someone do this for you.

The SPD is designed to make your benefits as clear to you as possible. However, nothing written in the SPD is meant to reinterpret, add to, or change in any way the legal provisions expressed in the Plan and in the Agreement and Declaration of Trust or in any insurance policies purchased by Teamsters Union 25 Health Services & Insurance Plan.

Important Addresses and Phone Numbers

Teamsters Union 25 Health Services & Insurance Plan		
Main Office Member Services Office Dental Office Board of Trustees	16 Sever Street Charlestown, MA 02129-1305	Local: 617-241-9220 In MA: 1-800-442-9939 Outside MA: 1-800-225-6135 Fax: 617-241-8168 website address: www.teamsterscare.com

TeamstersCare Dental Offices		
Charlestown:	16 Sever Street Charlestown, MA 02129-1305	Local: 617-241-9220 In MA: 1-800-442-9939 Outside MA:1-800-225-6135
Chelmsford:	4 Meeting House Road Chelmsford, MA 01824	Local: 978-256-9728 Toll free: 1-800-258-2111
Stoughton:	1214 Park Street Stoughton, MA 02072	Local: 781-297-7360 Toll free: 1- 877-326-1999

Dental Care		
Dental Blue Freedom	Contact BCBS Member Service to: -obtain a claim form (if not available from your dentist) -determine whether a particular dentist is in the Dental Blue Freedom network	Customer Service 1-800-241-0803
	Mail claim forms to: BCBSMA P.O. Box 986030 Boston, MA 02298	
	website for general information	www.bluecrossma.com

Vision Care		
Davis Vision	-to find a provider	Customer Service 1-800-999-5431
	website for general information	www.davisvision.com

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Teamsters CARE

Teamsters Union 25
Health Services & Insurance Plan
April, 2019