# SUMMARY PLAN DESCRIPTION

**of the**

## Plan of Benefits

**of the**

# TEAMSTERS JOINT COUNCIL NO. 53 RETIREE HEALTH AND WELFARE FUND

**August 2026**

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# INTRODUCTION

## About This Booklet

To All Eligible Participants:

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

This booklet, which also serves as the Plan Document, describes the Plan as in effect on July 1, 2026. The terms and conditions of the Plan, as well as the benefits provided through the Plan, are subject to change and/or amendment from time to time at the discretion of the Plan's Retirement Committee. Should changes be implemented, you will be sent a "Statement of Material Modification" describing any such changes. Such statements are generally sent via first class mail to the participant's last known address on file with the Plan.

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

Sincerely,

The Retirement Committee

# GENERAL INFORMATION

1. **Plan Identification:**

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

2. **The Plan Sponsor is:**

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

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

William Hamilton, Chairman
Daniel Grace
Spencer Dearth
Michael Bonaduce
Howard W. Wells, Treasurer
Dennis Hower
Joseph Smith
Robert "Rocky" Bryan, Jr.

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

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

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

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

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

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

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

**Actuarial Consultant:**
The McKeogh Company
1001 Conshohocken Rd
Suite 1-407
W Conshohocken, PA 19428

**Investment Consultant:**
RBC Wealth Management
181 Washington St, Ste 500
Conshohocken, PA 19428

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

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

**Dental Benefit Carrier:**
Fidelio Dental Insurance
2826 Mt. Carmel Ave
Glenside, PA 19035

**Vision Benefit Carrier:**
National Vision Administrators
1200 US Rt 46 West
Clifton, NJ 07013

**Rx Drug Benefit Manager:**
Capital RX Inc.
228 Park Ave S. Ste 87234
New York, NY 10003

6. **Financing** –

Benefits under the Plan are financed through Employer contributions and monthly premium copayments from eligible participants. The rate of Employer contributions and the cost of participant premium copayments are set from time to time by the Retirement Committee. As of August 1, 2026, the monthly participant premium copayments are as follows:

| | **Non-Medicare Eligible** | **Medicare Eligible** |
|---|---|---|
| Retirees | $233.52 per month | $110.13 per month |
| Dependents | $389.21 per month | $183.55 per month |

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

# ELIGIBILITY RULES

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

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

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

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

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

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

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

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

# CONTINUATION OF COVERAGE

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

**COBRA CONTINUATION COVERAGE**

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

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

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

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

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

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

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

***Certificate of Former Coverage***

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

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

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

***Special Rule for Multiple Qualifying Events***

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

***Special Rule for Totally Disabled Qualified Beneficiaries***

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

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

# PRIVACY PRACTICES

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

**DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION**

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

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

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

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

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

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

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

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

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

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

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

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

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

**YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION**

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

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

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

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

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

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

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

**DUTIES OF THE PLAN**

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

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

**CONTACT PERSON**

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

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

**EFFECTIVE DATE**

This Notice was effective April 14, 2004, was revised effective July 1, 2025, and, as revised, remains in effect as of this printing.

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

# EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")

## IMPORTANT INFORMATION REQUIRED BY ERISA

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

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

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

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

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

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

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

### IMPORTANT INFORMATION REQUIRED BY ERISA

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

**Receive Information About Your Plan and Benefits**

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

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

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

**Continuing Group Health Plan Coverage**

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

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

**Prudent Actions by Plan Fiduciaries**

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

**Enforcing Your Rights**

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

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

the materials, unless the materials are not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which are denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical support order, you may file suit in a federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these fees. If you lose, the court may order you to pay these costs and fees. For example: If it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

# PLAN CHANGE OR TERMINATION

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

Plan benefits and eligibility rules for active or disabled participants:

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

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

## BENEFITS PROVIDED UNDER THE PLAN

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

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

You are covered under:

| **If you are eligible and are:** | Teamsters Health and Welfare Fund | Medicare Supplement Plan* | Dental Program (Fidelio) | Prescription Drug Program (Capital RX) | Vision Program (NVA) |
|---|---|---|---|---|---|
| Underage 65 | **√** | | **√** | **√** | **√** |
| Age 65 or older | | **√** | **√** | **√** | **√** |

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

***To be considered timely filed, claims must be received by the Contract Administrator no later than one year following the date in which the claim was incurred.***

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

In addition, and in accordance with Federal law:

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

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

# COORDINATION/SUBROGATION OF BENEFITS

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

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

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

# CLAIMS APPEAL PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) **Pre-Service Claims**. In the case of a pre-service claim, the Plan or the PBM shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan or the PBM. This period may be extended one time by the Plan or the PBM for up to 15 days, provided the Plan or the PBM both determine that such an extension is necessary due to matters beyond the control of the Plan or the PBM, and notifies the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant

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

(4) **Post-Service Claims**. In the case of a post-service claim, the Plan shall notify the Claimant, in accordance with Paragraph d of this section, of the Plan's adverse benefit determination within a reasonable period, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan or the PBM for up to 15 days, provided that the Plan or the PBM both determines that such an extension is necessary due to matters beyond the control of the Plan or the PBM and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

g. **Right of Review**

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

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

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

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

(b) The Claimant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. Whether a document, record or other information

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

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

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

(e) If the adverse benefit determination was based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.

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

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

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

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

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

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

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

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

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

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

benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

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

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

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

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

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

# APPENDIX

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

# TEAMSTERS JOINT COUNCIL NO. 53
# RETIREE HEALTH AND WELFARE FUND

## MEDICARE SUPPLEMENTAL COVERAGE - 2026 DEDUCTIBLES AND COINSURANCE

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

| SERVICES | MEDICARE PAYS | SUPPLEMENT PLAN PAYS |
|---|---|---|
| HOSPITALIZATION<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | |
| First 60 days | All but $1,736 | $1,736 |
| Days 61-90 | All but $434/day | $434/day |
| After 90 days<br>For 60 Lifetime Reserve days | All but $868/day | $868/day |
| After Lifetime Reserve days are used | $0 | 100% of Medicare eligible expenses for additional 365 days |
| Beyond the additional 365 | $0 | $0 |
| SKILLED NURSING FACILITY<br>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility 30 days after leaving the hospital. | | |
| First 20 days | 100% | $0 |
| Days 21-100 | All but $217/day | $217/day |
| After 100 days | $0 | $0 |

| **Medicare Part B - Medical Services (per Calendar Year)** | | |
|---|---|---|
| SERVICES | MEDICARE PAYS | SUPPLEMENTAL PLAN PAYS |
| MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. | | |
| First $283 of Medicare-approved amounts | $0 | $283 |
| Remainder of Medicare-approved amounts | 80% (50% of outpatient psychiatric services) | 20% (50% of outpatient psychiatric services) |
| Part B excess charges (above Medicare-approved amounts) | $0 | $0 |
| **Medicare Parts A and B - Services** | | |
| HOME HEALTH CARE - MEDICARE/APPROVED SERVICES | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 |
| Durable medical equipment<br>First $240 of Medicare-approved amounts | $0 | $283 |
| Remainder of Medicare-approved amounts | 80% | 20% |

# Joint Council No. 53 Medical Coverage for Under 65 Participants

| ***Horizon Blue Cross Blue Shield*** | **PPO Platinum** |
|---|---|
| **Coverage Type** | In-network and out-of-network |
| **Network** | Horizon BCBS |
| **Overall Out-of-Pocket Maximum**<br>*In-network and out-of-network combined* | $5,000 individual / $10,000 family |
| **In-Network Benefits** | |
| **Deductible**<br>*Individual / family* | $200 / $400 |
| **Coinsurance** | 10% |
| **Coinsurance Out-of-Pocket Maximum**<br>*After this limit is met, coinsurance is reduced to 0% for the rest of the plan year. Copays continue to apply and count toward the overall out-of-pocket maximum.* | $500 |
| **Office Visits** | |
| Preventive care | Covered |
| Primary care physician / specialist | $20 / $30 |
| Diagnostic lab / X-ray | Deductible, then 10% |
| Urgent care | $50 |
| Acupuncture | $20 |
| **Hospital and Facility Services** | |
| Inpatient care | Deductible, then 10% |
| Outpatient surgery | Deductible, then 10% |
| Major diagnostics / imaging | Deductible, then 10% |
| Emergency room | $100 |
| **Out-of-Network Benefits** | |
| **Deductible**<br>*Individual / family* | $450 / $900 |
| **Coinsurance** | 20% |
| **Coinsurance Out-of-Pocket Maximum**<br>*After this limit is met, coinsurance is reduced to 0% for the rest of the plan year. Copays continue to apply and count toward the overall out-of-pocket maximum.* | $1,500 |

**TEAMSTERS JOINT COUNCIL NO. 53 RETIREE HEALTH AND WELFARE FUND**

**Capital Rx - Prescription Drug Coverage**

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

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

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

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

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

You may use any participating pharmacy to fill your prescription needs.

Capital Rx Scripts Customer Service Number is 1-844-542-2779.

# SUMMARY PLAN DESCRIPTION

# DENTAL PLAN

## Fidelio Dental Insurance

Fidelio
DENTAL INSURANCE

**Group Name:** Teamsters Joint Council 53 Health & Welfare Fund

**Plan Name:** Fidelio PPO

**Group #:** JC0526

## Introduction

This Summary Plan Description is written in an easy-to-understand way to explain the Group Dental Plan ("the Plan") and provide information on the Plan which you may need in the future. If you have any questions after reading this Summary Plan Description, contact your plan administrator or call Fidelio Dental directly.

The Plan is intended to provide dental benefits for eligible Members.

## How to Contact Us

If you have any questions about your dental coverage that are not addressed in this document, Fidelio is here to help. For comprehensive information, you can visit our official website at www.fideliodental.com. Alternatively, you can reach out to our Customer Care Team where trained representatives are available to assist you with various concerns—from understanding your benefits and locating a participating network dentist to checking the status of a claim or helping you file one.

Our Customer Care Team is available Monday through Friday, from 8:30 a.m. to 5:00 p.m. Eastern Time. You can reach us by phone at (215) 885-2443.

You may also contact us via mail by sending inquiries to 2826 Mt. Carmel Avenue, Glenside, PA 19038.

## How the Dental Plan Works

### Choice of Dentist

You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a Fidelio participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles, or amounts exceeding the program maximum. Participating dentists will also complete and send claims directly to Fidelio.

If you go to a dentist who is not a Fidelio participating dentist, you may have to pay the dentist at the time of service. In addition to any coinsurance or deductible, you will also have to pay the difference between the dentist's charge and the amount that the Plan allows.

To find a participating dentist, visit Find a Dentist on Fidelio's Subscriber Login at www.fideliodental.com or telephone at (215) 885-2443.

When you visit the dental office, let your dentist know that you are covered under a Fidelio program. If your dentist has questions about your eligibility or benefits, instruct the office to call Fidelio.

### Claims Submission and Payment

Fidelio Dental keeps the claim process simple. Most dental clinics are equipped with standard claim forms for your convenience. If you visit a Participating Dentist, they will handle and submit your claim paperwork on your behalf. Most Non-Participating Dentists might also offer this service if you ask. However, if your Non-Participating Dentist does not offer this service, you can take the initiative to send your claim directly to Fidelio Dental.

### Pre-Determination Estimates

When uncertain about your coverage for a specific dental procedure, especially if the anticipated costs surpass $300, Fidelio Dental suggests obtaining a pre-treatment estimate. You should request your dentist to forward the claim form prior to initiating the proposed treatment.

Fidelio DENTAL INSURANCE

# Plan Benefit Summary

**Group Name:** Teamsters Joint Council 53 Health & Welfare Fund
**Group #:** JC0526

| Contract Benefit Levels | | |
|---|---|---|
| | **In-Network Providers[1]** | **Out-of-Network Providers[2]** |
| **Annual Maximum** | $1,500 | $1,500 |
| **Individual Deductible** | None | None |
| **Family Deductible** | None | None |
| **Coverage Levels** | **In-Network Providers[1]** | **Out-of-Network Providers[2]** |
| **Diagnostic & Preventive Services** | 100% | 100% |
| **Basic Services** | 100% | 100% |
| **Endodontics** | 100% | 100% |
| **Periodontics** | 50% | 50% |
| **Oral Surgery** | 50% | 50% |
| **Major Services** | 50% | 50% |
| **Prosthodontics** | 50% | 50% |

[1] In-Network Providers have reduced fees contracted with Fidelio.
[2] Out-of-Network Providers are reimbursed based on the Maximum Allowable Charge determined by Fidelio.

| Orthodontic Coverage | | |
|---|---|---|
| | **In-Network Providers[1]** | **Out-of-Network Providers[2]** |
| **Orthodontic** | None | None |
| **Lifetime Orthodontic Maximum** | None | None |
| **Age Limit** | None | None |

[1]**In-Network Benefits** means benefits under this plan for covered dental services that are provided by a participating Fidelio In-Network Provider under a negotiated fee schedule.

[2]**Out-of-Network** means benefits under this plan for covered dental services that are not provided by a participating Fidelio In-Network Provider. Those using Out-of-Network Providers are subject to balance billing (difference between the provider charge and the Fidelio payment).

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Standard eligibility requirements apply. Please refer to the plans eligibility details to ensure coverage.

# Plan Benefit Details

**Limitations**

The listing below is a list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.

1. Exam and cleaning limitations:
   - We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings no more than twice in a twelve-month period.
   - A full-mouth debridement is allowed once in a lifetime. When allowed, a full-mouth debridement counts toward the maintenance frequency in the year provided.
   - Full-mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
   - Periodontal maintenance procedure codes are covered as a Basic Benefit.
2. X-ray limitations:
   - We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intra-oral series when the fees for any combination of intra-oral x-rays in a single treatment series meet or exceed that fee.
   - When a panoramic film is submitted with supplemental film(s), we will limit reimbursement to the Accepted Fee for a complete intra-oral series.
   - If a panoramic film is taken in conjunction with an intra-oral complete series, the panoramic film is included in the complete series allowance.
   - A complete intra-oral series or a panoramic film are each limited to once every 36 months.
   - Bitewing x-rays are limited to once in a twelve-month period per Enrollee up to four images.
   - Occlusal images are limited to two per 12 months and Periapical X-Rays are limited to seven per visit (if the combination of 8 or more images will be paid for at the FMX).
   - 2D Photographic Images are limited to once per lifetime.
   - Image-capture procedures are not separately allowable services.
3. Topical application of fluoride solutions is limited to once in a twelve-month period under age 16.
4. Space maintainer limitations:
   - Space maintainers are limited to once per tooth per lifetime.
5. Cephalometric x-rays, oral/facial photographic images, and diagnostic casts are covered once per 36 months in conjunction with Orthodontic Services only when Orthodontic Services are a covered Benefit; 3-D x-rays are not covered.
6. Sealants are limited to:
   - Limited to once per 36 months under age 16 on unrestored molars (teeth 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32).
7. We do not cover replacement of an amalgam or resin-based composite restoration or prefabricated crown within 12 months when provided by the same Provider/office; such replacement is included in the original fee.
8. Protective restorations are allowed once per 12 months.
9. Therapeutic pulpotomy is limited to once per tooth per lifetime.
10. Pulpal therapy (resorbable filling) is limited to once per tooth per lifetime. Retreatment of root-canal therapy by the same Provider/office within 12 months is considered part of the original procedure.
11. Apicoectomy is covered once per tooth per lifetime.
12. Periodontal limitations:
    - Scaling and root planing is limitation are the following; Each of the four quadrants are payable once in any 24 month period. If more than two quadrants are performed on same date of service, the alternate benefit of a full mouth debridement is applied and will count towards the frequency of the cleanings.

- Periodontal surgery in the same quadrant is limited to once every 24 months and includes any re-entry or scaling and root planing performed within that period by the same Provider/office.
- Cleanings (regular and periodontal) and full-mouth debridement are subject to a 30-day wait after scaling and root planing if performed by the same office.

13. Crowns and inlays/onlays are limited no more than once every 60 months unless current restorations are unsatisfactory and cannot be made satisfactory.

14. Core buildups, including any pins, are covered no more than once every 60 months.
15. Post-and-core services are covered no more than once every 60 months.
16. Crown repairs are covered no more than once per 12 months; crowns, inlays/onlays, and fixed bridges include repairs for 12 months after installation.
17. Denture repairs are covered no more than once per arch per 12-month period.
18. Covered implant placement procedures include the surgical placement of an implant body (endosteal implant), a mini implant, an eposteal (subperiosteal) implant, or a transosteal implant. A benefit is payable for only one implant—of any type—for each individual tooth during the Member's lifetime, and once a benefit has been paid for an implant at a particular tooth position, no further implant placement for that position will be covered, even if the original implant is lost, removed, or fails.
19. Coverage for an implant abutment, whether healing or definitive, is limited to one abutment per tooth within any 60-month period; any additional abutments for the same implant site before sixty months have elapsed are not covered.
20. Implant maintenance—including removal of the implant-supported prosthesis, cleaning of the implant and prosthesis, and reinsertion—is covered once per dental arch every six months, and maintenance performed more frequently than once per arch in a six-month period is not eligible for benefits.
21. Prosthodontic appliances, implants, and implant-supported prosthetics provided under any Fidelio program will be replaced only after 60 months, unless we determine the existing appliance cannot be made satisfactory. Replacement of an appliance not provided under a Fidelio program will be made if deemed unsatisfactory.
22. When a posterior fixed bridge and a removable partial denture are placed in the same arch during the same treatment episode, only the partial denture will be a Benefit.
23. Recementation of crowns, inlays/onlays, or bridges is included in the original fee if performed by the same Provider/office within six months; after six months, payment is limited to one recementation per 12 months by the same Provider/office.
24. We limit payment for dentures to a standard partial or complete denture. A standard denture is a removable appliance replacing missing natural permanent teeth, made from acceptable materials by conventional means, and includes routine post-delivery care for six months.
    - Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for six months.
    - Dentures and relines include adjustments for six months; after that, adjustments are limited to one per arch in a 24-month period, and relines are limited to one per arch in a 24-month period.
    - Tissue conditioning is limited to one per arch in a 12-month period and is not allowed separately when done on the same day as a denture, reline, or rebase.
    - Recementation of fixed partial dentures is limited to once in a 12-month period.
25. Fees for synchronous/asynchronous teledentistry are considered part of overall patient management and are not separately payable.

**Exclusions**:

1. Treatment of injuries or illness covered by workers'-compensation or employers'-liability laws, or services received without cost from any federal, state, or local agency (unless prohibited by law).
2. Cosmetic surgery or purely cosmetic procedures.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations.
5. Services for congenital or developmental malformations.
6. Treatment to stabilize teeth, restore structure lost from wear/erosion/abrasion, or rebuild chewing surfaces due to malalignment or occlusion, including but not limited to equilibration, periodontal splinting, occlusal adjustments, night guards/occlusal guards, and abfraction.
7. Any single procedure provided before the Enrollee became eligible under this plan.
8. Prescribed drugs, medications, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Anesthesia charges other than general anesthesia and IV sedation administered by a Provider for covered oral-surgery or selected endodontic/periodontal procedures; local and regional anesthesia are not separately payable.
10. Extra-oral grafts (grafting tissues from outside the mouth to oral tissues).
11. Indirectly fabricated resin-based inlays/onlays.
12. Hospital or surgical-facility charges and any additional fees charged by the Provider for treatment in such facilities.
13. Treatment by someone other than a Provider or a legally supervised auxiliary.
14. Charges for oral-hygiene instruction, plaque-control programs, dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
15. Dental-practice administrative services, infection-control supplies, or ancillary materials used routinely in treatment, and relaxation techniques.
16. Procedures with a questionable prognosis based on a dental consultant's review.
17. Any tax imposed in connection with fees for Benefits—this is the Enrollee's responsibility.
18. Deductibles, amounts over plan maximums, or any service not covered under the plan.
19. Services that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
20. Orthodontic treatment except as specifically provided under Orthodontic Services.
21. Treatment of temporomandibular-joint (TMJ) disorders except as specifically provided.
22. Missed or cancelled appointments.
23. Scheduling and compliance services—they are part of normal office operations and not separately payable.
24. Fees for care coordination—considered inclusive in patient management.
25. Dental-case-management motivational interviewing and patient-education services to improve oral-health literacy.
26. Non-ionizing diagnostic procedures that quantify or monitor enamel, dentin, or cementum changes.
27. Extra-oral 2-D projection or extra-oral posterior dental radiographic images.
28. Diabetes testing.
29. Corticotomy associated with orthodontics.
30. Antigen or antibody testing.
31. Counseling for controlling adverse oral, behavioral, or systemic effects related to high-risk substance use.
32. Caries-risk assessments.
33. Apexification.
34. Frenulectomy.
35. Interim caries-arresting medicament application.
36. Recementation and removal of a space maintainer.
37. Pulp vitality tests.
38. Repair or replacement for sealants.
39. Screenings or specialist consultations.
40. Bone grafts, guided tissue regeneration, graft procedures, and biologic materials.
41. Transseptal fiberotomy/supracrestal fiberotomy.

National Vision Administrators, L.L.C.

# Your NVA Vision Benefit Summary

## Teamsters Joint Council #53 Retiree Health & Welfare Fund
**Effective 01/01/2025**
**Group Number# 4281**

## Schedule of Vision Benefits

| Benefit Frequency | Participating Provider | Non-Participating Provider |
|---|---|---|
| **Examination**<br>Once Every Calendar Year | ▪ Covered 100% | Reimbursed Amount<br>▪ Up to $40 |
| **Lenses**<br>Once Every Two Calendar Years | Standard Glass or Plastic | |
| ▪ Single Vision | ▪ Covered 100% | ▪ Up to $40 |
| ▪ Bifocal | ▪ After $15 copay | ▪ Up to $50 |
| ▪ Trifocal | | ▪ Up to $75 |
| ▪ Lenticular | | ▪ Up to $100 |
| ▪ Polycarbonates | ▪ Covered 100% | ▪ Up to $25 (SV)<br>▪ Up to $30 (Bi/Tri) |
| ▪ Standard Scratch Coating | ▪ Covered 100% | ▪ Up to $10 |
| ▪ Blended Bifocal (Segment) | ▪ Covered 100% | ▪ Up to $30 |
| ▪ Progressives – Tier 1 | ▪ Covered 100% | ▪ Up to $50 |
| **Frame**<br>Once Every Two Calendar Years | Retail Allowance<br>▪ Up to $200 (20% discount off balance)* | ▪ Up to $50 |
| **Contact Lenses**<br>Once Every Two Calendar Years | In lieu of Lenses & Frame | In lieu of Lenses & Frame |
| Elective Contact Lenses | ▪ Up to $110 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)** | ▪ Up to $150 |
| Fit/Follow-Up*** | | |
| Standard Daily Wear | ▪ Covered 100% after $20 copay | ▪ Up to $20 |
| Standard Extended Wear | ▪ Covered 100% after $30 copay | ▪ Up to $30 |
| Specialty Wear | ▪ Covered 100% after $50 copay | ▪ Up to $50 |
| Medically Necessary**** | ▪ Covered 100% | ▪ Up to $300 |

## How Your Vision Care Program Works

**Eligible members are entitled to receive a vision examination once every calendar year and one (1) pair of lenses and a frame or contact lenses and contact lens evaluation/fitting once every two calendar years.**

**For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.**

**Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.**

**To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.**

**If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 4281000001 or the group number on the identification card and enter in your search parameters. It's that easy!**

*Does not apply to Lenscrafters locations or for certain proprietary brands.
**Does not apply to Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target & Pearle and may be prohibited by some manufacturers.
***Only covered if you choose Contact Lenses.
****Pre-approval from NVA required.

**Fixed prices/courtesy discount do not apply at LensCrafters locations.**
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $39 Retinal Screening
- $12 Ultraviolet Coating
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- $80 AR Coating – Tier 4
- 20% discount AR Coating – Tier 5
- $10 Solid Tint
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8

**For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Visionworks, etc.) are independent providers and may not participate in the NVA program.**

# Get a Better View

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

**Plan Specific Details Online**: The NVA website is easy to use and provides the most up to date information for program participants:
*-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent*
*-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network*

**Examinations***:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

**Lenses**: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

**Frames**: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

**Contact Lenses:** The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

**Non-Participating Providers:** You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

**Laser Eye Surgery:** NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

**Hearing Discount:** You will receive up to 60% savings at participating provider locations through NationsHearing®.

**Discounts:** In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

**Your NVA EyeEssential® Plan Discount – In Network Only**

| Service | Participating Provider | Lens Options |
|---|---|---|
| | **Member Cost:** | |
| **Eye Examination:** | Retail Less $10 | $12 Solid Tint/ Gradient Tint<br>$50 Standard Progressive Lenses |
| **Contact Lens Fitting:** | Retail Less 10% | $75 Polarized Lenses<br>$65 Transitions Single Vision Standard |
| **Lenses:** | Glass or Plastic | $70 Transitions Multi-Focal Standard<br>$15 Standard Scratch Coating |
| Single Vision | $35.00 | $12 UV Coating |
| Bifocal | $55.00 | $35 Polycarbonate |
| Trifocal or Lenticular | $70.00 | $45 Standard Anti-Reflective |
| **Frame:** | Retail Less 35% | |
| **Contact Lenses*:** | **Member Cost:** | |
| Conventional | Retail Less 15% | |
| Disposable | Retail Less 10% | |

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price.

Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., Lenscrfafters, Visionworks, etc.) are independent providers and may not participate in the NVA program.

## At NVA, We Work Only for Our Clients.

**Exclusions / Limitations***:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

**National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015**
**Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723**
**NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.**

***This document is intended as a program overview only and is not a certified document of the individual plan parameters.***

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