PLEASE READ THIS DOCUMENT CAREFULLY AND KEEP IT IN A SAFE PLACE

SUMMARY OF MATERIAL MODIFICATIONS #21

Date: January 13, 2025

To: All Participants
Teamsters Local 639 – Employers Health Trust Fund

From: The Board of Trustees of the Teamsters Local 639 – Employers Health Trust

Subject: Notice of Dental Benefit Changes

This Notice announces important changes to the Plan's Dental Benefit Program.

Effective February 1, 2025, the Teamsters Local 639 – Employers Health Trust Fund (the "Plan") will transition to a new dental provider. Starting on this date, dental benefits under the Plan will be provided through Cigna Dental Care ("Cigna DHMO") instead of Dental Health Centers ("DHC").

Here's how the Cigna DHMO works:

The Cigna DHMO Network

Cigna DHMO has a large network with over 18,000 participating dentists to choose from as well as 6,900 participating dental specialists. You **must** select a general dentist in the Cigna DHMO network to manage your overall care, and you **must** visit that dentist in order to have your dental benefits covered. **No dental benefits will be provided by the Plan if you choose to go to an out-of-network dentist.** The good news is that with such a large network, you should be able to see an in-network dentist and have many of your dental needs covered at no charge (see below). Also, several dentists who participate in the DHC network also participate in the Cigna DHMO network. If your dentist is not in the Cigna DHMO network, you can nominate them for Cigna to recruit into the Cigna DHMO network. A provider nomination form is available from the Fund Office.

You can search for general dentists on www.mycigna.com or by calling 800.Cigna24 (800.244.6224). You can select the same or a different dentist for each of the covered members of your family. Cigna will assign a network general dentist to you that is within 25 miles of your location. You may change this selection on or after February 1, 2025. If needed, your general dentist will refer you to an appropriate specialist. This referral from your general dentist is required; without it, any services rendered by the specialist will not be covered.

Cigna DHMO Coverage

Most of the dental benefits coverage under the Cigna DHMO will remain the same as the coverage you received under the DHC plan, and many benefits and costs are improving. However, the Cigna DHMO is a copayment plan – meaning you pay a fixed dollar amount to your network dentist for the covered service(s) you receive in addition to any allowable charge for upgraded materials, and you do not have to meet a deductible before coverage begins. For example, diagnostic and preventive care services (e.g., biannual cleanings, x-rays, and exams) are generally covered with a $0 copay, but basic restorative services (e.g., fillings) are subject to a copay between $0 and $40 depending on the service. More complex services, like endodontics (e.g., root canal treatment, excluding final restorations), are subject to a copayment of up to $90 depending on the service, and periodontics (e.g., treatment of gum and bone that supports the teeth) are subject to a copay between $30 and $255.

This difference in how services are billed under the Cigna DHMO plan may result in a modest cost increase to you for certain services, but in most instances, you would have had to pay more under the DHC plan. Under the DHC plan, you were responsible for 25% of the cost of the entire service, which is more than most of the applicable copays under the Cigna DHMO. In addition, while the DHC plan imposed an annual maximum benefit of $4,000 per family, there are no annual dollar maximums under the Cigna DHMO. The Cigna DHMO only has a 24-month active treatment limitation on orthodontia, which means that orthodontic cases beyond 24 months generally require an additional payment.

A listing of the Cigna DHMO services covered and the copay schedule is posted on the Plan's website at www.ourbenefitoffice.com/teamsterslocal639trustfunds/benefits.

Continuation of Care

If you or one of your dependents is in the middle of a dental treatment that was started before January 31, 2025 (e.g., a root canal, crown or bridge work), you will be allowed to complete that treatment with your current dentist, even if the work is performed after January 31, 2025 at the costs provided through DHC. You will need to contact DHC to complete the work before February 28, 2025. If continuation of care is not available through DHC, you must complete and submit a transition of care/continuity of care request to Cigna within 30 days of becoming active for Cigna to cover the remainder of the treatment. Call Cigna customer service 24/7 at 800.Cigna24 (800.244.6224) to request the transition of care/continuity of care paperwork.

The Fund Office is also working with both the Cigna DHMO and DHC to provide continuation care for dependents who are in the middle of orthodontia treatment to allow them to continue treatment with their current orthodontists. Please contact Cigna after February 1, 2024 to obtain details on the continuation of coverage process.

Plan Materials

You will soon be receiving a welcome packet from Cigna which will include information about the DHMO and choosing an in-network dentist. You will also receive more detail about the specific benefits of the Cigna DHMO. Until then, you can find more information on the Plan's website at www.ourbenefitoffice.com/teamsterslocal639trustfunds/benefits.

ID Cards

You will receive a NEW medical/prescription identification card with the new which include Cigna's contact information on the back. You will also receive a separate Cigna dental ID card in the mail.

Questions

If you have any questions about this notice, your health benefits or eligibility, you can contact the Fund Office at (202) 636-8181 or toll-free at (800) 983-2699, Monday through Friday from 9:00 a.m. until 5:00 p.m. Additionally, you may visit the Fund Office in-person.

GRANDFATHERED HEALTH PLAN

This group health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. 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. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Please Note: *The Trustees reserve the right to amend, modify, or terminate the Plan and any or all benefits provided thereunder.*