SECTION ONE: Basic Plan Information

This Summary Plan Description provides general information about your Teamsters Local 251 Health Services and Insurance Plan ("Plan").

I. Introduction

This Summary Plan Description ("SPD") is the Master Plan Document. It is important that you and your dependents review this document. It will help you understand your benefits and use them well. Among other things, this SPD will provide you with an understanding of:

- When coverage begins and ends;
- The benefits provided;
- The procedures to follow in submitting claims and appeals; and
- Your responsibility for providing necessary information to the Plan

If you have questions about this SPD, contact the Fund Office at (401) 467-3323.

Please be aware that, unless otherwise stated, when this SPD refers to "you" it is referring to the participant.

A. The Trustees Have Exclusive Discretionary Authority to Amend, Terminate or Interpret the Plan

Nothing in this Summary Plan Description is meant to interpret or extend or change in any way the provisions expressed in the Plan. None of the benefits provided by this Plan are vested or guaranteed in any way. The Trustees have the exclusive discretionary authority to amend, modify or discontinue all or part of this Plan, the Trust Agreement or any other Plan documents at any time. No change in this SPD will be valid unless authorized by the Trustees.

No person is authorized to do any of the following without the express authority of the Trustees acting in their capacity as Trustees;

(a) change, amend or interpret this SPD;
(b) waive any condition or restriction contained in this SPD;
(c) extend the time for making any contribution or payment; or
(d) bind the Trustees by any statement or promise.

Accordingly, no Local Union Officer, Business Agent, Local Union Employee, Employer Representative, Fund Office personnel, consultant or attorney is authorized to speak for or on behalf of, or to commit the Trustees of this Plan on any matter relating to the Plan without the express authority of the Trustees. The written terms of the Plan take precedent over representations regarding the Plan made by anyone other than the Trustees acting in their capacity as Trustees. If you have any questions regarding the terms of the Plan, contact the Fund office and you will be directed to the appropriate written Plan terms.

Only the Trustees of the Plan have the discretionary authority to determine eligibility for benefits and the right to participate in the Plan. This includes but is not limited to: The manner in which hours are credited, eligibility for any benefits, discontinuance of benefits, status as covered or non-covered participant, the level of benefits and interpretation and application of rules and regulations to a particular claim or application.

All determinations made by the Board of Trustees with respect to any matters arising under the Plan, Trust Agreement and any other Plan documents shall be final and binding on all affected Plan Participants and their dependents.

II. Important Information Regarding Fraud and Termination of Coverage

Any act, practice, or omission by an individual that constitutes fraud or an intentional misrepresentation of material fact to the Fund is prohibited under the term of this Summary Plan Description.

Failure to provide timely notice to the Fund of a change in status, including, but not limited to, a change in status resulting from divorce or the availability of other health insurance coverage, is an intentional misrepresentation of material fact.

It is a Federal Crime to knowingly defraud a health care benefit program. (See Section Two page 18 U.S.C.A. § 1035.) The Fund will terminate coverage for you and your dependents if the Trustees, in their sole discretion, determine that you or your legal representative knowingly provided false information, directly or indirectly, with the intent to cause the Fund to provide coverage, benefits, or payments that you or a third party were not entitled to receive. Furthermore, in the event that you defraud or attempt to defraud the Fund, the Fund may elect to pursue legal action against you.

III. Important Phone Numbers

You may always call the Fund Office at **(401) 467-3323** or **1 (800) 542-2411** if you have a question about any of your benefits, but here are some other contacts to help you get answers to your benefit questions quickly.

For Questions About . . .	Contact	Phone Number	Website
Coastline **EAP**	300 Centerville Rd Suite 301 South Warwick, RI 02886-0219	24 hours/7 days a week 1-(800)-445-1195	www.coastlineeap.com
Dental	Delta Dental of Rhode Island	For Participating Providers: (401) 752-6100 1 (800) 843-3582	www.deltadentalri.com
Hearing (Level 1 & Level 1 EBL)	Sargent Rehabilitation Center 800 Quaker Lane Warwick, RI 02818	(401) 886-6600	www.sargentcenter.org
Legal	ARAG Legal Center	Customer Care Counselor 1 (800) 247-4184	www.ARAGLegalCenter.com
Life Insurance (Level 1 & Level 1 EBL)	Aetna Inc. 151 Farmington Avenue Hartford, CT 06156	Customer Service: 1 (800) 523-5065	www.aetna.com
Medical	UnitedHealthcare 475 Kilvert Street Warwick, RI 02886	For Participating Providers: 1 (877) 842-3210 For Preauthorization: 1 (866)527-9596 Customer Service: 1 (866) 527-9596 Mental Health and Chemical Dependency Treatment: 1 (866) 527-9596	For general information or to find a participating provider: www.myuhc.com

For Questions About . . .	Contact	Phone Number	Website
Pharmacy Manager	CVS Caremark	**Mail Order prescriptions:** PO Box 94460 Palatine, IL 60094-9836 1 (888) 543-5940	www.caremark.com
Teamsters Health Services	1201 Elmwood Ave Providence, RI 02907-3799	Hours of operation Monday thru Friday 7:30 am – 4:30 pm (401) 467-3323 phone (401) 467-9480 fax	www.teamsters251hsip.org
Vision (Level 1 & Level 1 EBL)	Davis Vision	Customer Service: 1(800) 999-5431	www.davisvision.com

IV. Important Information About Your Plan

A. Administration

The Plan is administered by a Board of Trustees, consisting of three (3) Union representatives and three (3) Employer representatives who serve without pay. Together they manage the overall direction of the Fund. At their sole discretion, they decide how to interpret and administer the Plan and whether to change, add or delete benefits.

The Fund Office staff carries out the day-to-day operations of the Plan. These benefit professionals check member and dependent eligibility, monitor Employer contributions, answer questions about Plan benefits, and refer benefit-related issues to the Trustees to be resolved.

B. Basic Plan Information

Name of Plan	Teamsters Local 251 Health Services and Insurance Plan
Type of Plan	Health and Welfare Plan
Name of Plan Sponsor	Board of Trustees of the Teamsters Local 251 Health Services and Insurance Plan
Agent for Legal Process	The Board of Trustees

Plan Administrator	The Board of Trustees
Type of Administration	Collectively Bargained, jointly Trusteed Labor Management Trust
Plan Number	501
IRS Employer Identification Number	05-0367950
Plan Year	July 1 to June 30
Sources of Plan Financing	All contributions to the Plan are made by employers in accordance with collective bargaining agreements between Local Union 251 of the International Brotherhood of Teamsters and contributing employers. Participants may make contributions as provided by applicable collective bargaining agreements or COBRA, the federal law, for a limited period of time. Benefits are provided from the Fund's assets that are accumulated under the provisions of the collective bargaining agreement and Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expense. Some of the benefits are provided through insurance policies (i.e. Life Insurance and Accidental Death and Personal Loss coverage). The Fund Office will provide, upon written request, the information as to whether a particular employer is contributing to the Plan on behalf of participants working under a collective bargaining agreement.

C. Trustees' Right to Information

The Plan may require you to submit additional information that they believe is important for them to interpret and apply the terms of this Plan. Any participant who fails to comply with the Plan's request for information may have their benefits suspended or terminated at the Trustees' discretion.

D. Your ERISA Rights

As a participant in the Teamsters Local 251 Health Services and Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

As a participant, you are entitled to:

a. Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all

documents governing the Plan, including insurance contracts and collective bargaining 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.

b. Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may charge a reasonable charge for the copies.

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

2. 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 dependents. 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 benefits through Plan or exercising your rights under ERISA.

3. Continued Group Health Plan Coverage

You have the right to continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents would 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.

There may be other coverage options for you and your family. You may be eligible to buy coverage through the Health Insurance Marketplace, www.healthcare.gov. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for (but not enrolled in) COBRA does not limit your potential eligibility for coverage for a tax credit through the Marketplace.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272 For more information about

health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

4. Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you 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 your rights as a participant. 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 Fund 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 have a claim for benefits which is denied or ignored, in whole or in part, you may 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. If it should happen that 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. If you file suit, 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.

5. The Affordable Care Act

This group health plan believes it 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.

6. Rights of Appeal

You have the right to appeal to the Board of Trustees any adverse benefit determination including the loss of your eligibility status under the Plan. The Board of Trustees has full and absolute discretion, authority and power to interpret and apply the terms of the Plan and SPD. All determinations made by the Board of Trustees with respect to any matters arising under the Plan, Trust Agreement and any other Plan documents shall be final and binding on all affected Plan Participants and their dependents.

Generally, except for questions of eligibility to participate in the Plan and the determination of eligibility for Weekly Accident and Sickness Benefits, the Board of Trustees does not examine benefit determinations made by other providers (such as UnitedHealthcare) or insurance carriers. Claims for benefits under such arrangements must first be pursued using the claims and appeals procedures provided by the provider or insurance carrier. However, the Trustees have final discretionary authority over all claims paid out of plan assets. *See Section Sixteen for additional information regarding claims and appeal procedures*.

IMPORTANT NOTE: In all cases, provisions under the various claims procedures require that claims for benefits or reimbursement for medical services and appeals from the denial of claims must be submitted within a specific period of time. A failure to meet these time limits may bar the claim or appeal.

E. Assistance with Your Questions

If you have any questions about your Plan, you should call the appropriate phone number listed in the "Important Phone Numbers" chart or contact the Fund Office. If you have any questions about this SPD or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, 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 D.C. 20210, or visit the U.S. Department of Labor Employee Benefits Security Administration customer assistance website at https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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.