

East Bay Drayage Drivers Security Fund Plan 1980 for Active Employees

Teamsters Local 70 and your employer have worked together to provide you with a comprehensive program of health and welfare benefits. This program for Active employees, established as a result of collective bargaining, is financed by employer contributions to the East Bay Drayage Drivers Security Fund (the “Trust Fund”). The Trust Fund’s overall goal in creating and administering this program is to lessen the financial burdens caused by unforeseen illness or injury. Benefits for Retirees are described in a separate booklet.

Please read this booklet carefully. It is intended to be your primary resource for information about your health and welfare benefits. We have tried to present this benefit plan in a comprehensive, straightforward manner so that you may understand the value of your benefits. The Board of Trustees may find it necessary to change the provisions of the Plan from time to time. When this occurs, you will be notified.

This booklet has been designed to provide you with answers to questions you might have about your health and welfare benefits. If you need additional information, you may contact the Administrator’s Office by telephone at (800) 422-6099.

The Administrator will provide answers on the telephone on an informal basis. However, no such oral communication is binding on the Board of Trustees.

Since the last printing of the Summary Plan Description in 1998 the Fund has made some **changes in your Plan including the following:**

- **When last printed in 1998 the medical plan was insured by the Union Labor Life Insurance Company. That contract ended in 2008 and, although certain benefits described in this booklet – like life insurance – remain fully insured by Union Labor Life, if you are not enrolled in an HMO your medical benefits are now “self-insured” by the Trust Fund. A fuller description of what that means can be found on page 20.**
- **The Plan of Benefits described in this booklet is a “grandfathered” plan under the terms of the Patient Protection and Affordable Care Act of 2010 (“PPACA”). This booklet reflects the provisions of that Act applicable to the Plan as of the start of the October 1, 2010 Plan Year.**
- **Conformance of the Plan to the requirements of the PPACA applicable to grandfathered**

plans – most significantly by removing the Plan’s *lifetime* medical maximum (page 22).

- The appointment of New Trustees listed on pages 60-61.
- A one year limitations period on any lawsuit brought concerning claims denials and appeals (see page 69).

An Important Note

This booklet provides a summary of your health and welfare benefits through the Trust Fund. As a summary, certain questions concerning your benefits will require answers not found within this booklet. These questions are resolved by the Fund’s Board of Trustees. Only the Board of Trustees is authorized to interpret the Plan described in this booklet. No individual Trustee, Employer or Union representative is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The benefit programs and policies described in this booklet are current as of January 1, 2011, unless specifically stated otherwise.

Who Is Eligible for Benefits

Covered Employees

- **Your Initial Eligibility Date**

There are two requirements for initial eligibility – Your Employer makes the required contributions on your behalf *and* your submission to the Administration Office of the Plan’s enrollment form. **You first become eligible for the Plan on the first day of the calendar month following the completion of three (3) calendar months during any twelve (12) month period on your employer’s payroll during which your employer makes the monthly contributions required by the collective bargaining agreement on your behalf.**

For example, if you are hired in January, are employed for the hours required under your collective bargaining agreement for contributions to be made on your behalf for the months of January, February and March, and your employer makes the contributions required under the collective bargaining agreement on your behalf for those months, you will become eligible for benefits as of April 1 (upon receipt by the Fund of contributions in April for March hours) provided that you have submitted a fully completed enrollment form. **Eligibility for benefits will not begin until the Administrator’s Office has received your enrollment form.** Enrollment forms can be obtained from Local 70’s Health & Welfare office or from the Fund Administrator’s Office. To ensure that you are eligible for benefits as

early as possible, submit your enrollment form *before* your employer makes all three months' contributions on your behalf.

If your collective bargaining agreement does not specify the number of hours required for contributions to be made on your behalf, the Plan requires contributions if you are employed **80 hours** or more during any month.

The Fund waives this "three-months of contributions prior to coverage" waiting period if you were (1) previously covered by this Fund, or (2) covered by another Teamster health fund within twelve (12) months of the start of your current employment. If you qualify for this waiver, you become eligible on the first day of the month following the first month in which you work the hours required under your collective bargaining agreement provided that (1) your employer makes the required contribution; (2) you submit the Plan enrollment forms; and (3) you have established to the satisfaction of the Board of Trustees that you are entitled to the waiver.

- **Continuing Your Eligibility**

After you have met the initial eligibility requirements, you will maintain your eligibility from month to month thereafter if:

- You have worked the hours required under the collective bargaining agreement for a contribution to be made on your behalf *and* if your employer makes the required contribution to the Trust Fund on your behalf, *or*
- You are not working but the collective bargaining agreement requires your employer to make payments on your behalf, nevertheless.

Contributions paid for hours worked in one month pay for coverage in the following month. For example, contributions for hours worked in March pay for April coverage.

Unless your collective bargaining agreement specifically states otherwise, paid time, such as but not limited to vacations, sick leave and holidays, is considered time worked for purposes of determining eligibility and your employer's obligation to contribute.

- **Dependent Eligibility**

Eligible dependents who can participate in the Plan include:

- Your legal spouse;
- Your domestic partner (the eligibility requirements for domestic partners are outlined under "*Domestic Partner*" on page 4);

- Your children – from birth or legal adoption, stepchild(ren), a child placed for adoption, children for whom you have been appointed legal guardian by court order, or a child subject to a valid Qualified Medical Child Support Order – under age twenty-six (26) and, if over age eighteen (18), not eligible for coverage in a group health plan through their own employment, or on active duty military, naval or air service; and
- Your unmarried mentally or physically handicapped children age twenty-six (26) or older who are unable to support themselves for as long as they are so disabled and remain dependent on you (proof of the ongoing disability will be required within thirty one (31) days of your child reaching age twenty six (26) and at any other time requested by the Fund).
- **Your Dependents’ Eligibility Date (for Dependents other than Domestic Partners)**

If you have dependents on the date you first become eligible, your dependents also become eligible on that date. If you acquire a dependent *after* you first become eligible, the dependent becomes eligible:

- On the date you legally marry the dependent;
- On the date you assume legal responsibility for a dependent child who is within the applicable age limits described above;
- On the date that you have fully completed the requirements described under the heading “Application Process for Domestic Partner Coverage.”

Domestic Partners

In addition to a lawful spouse and dependent child(ren), a “domestic partner” is also eligible for coverage. A domestic partner may be of the same or opposite sex and must meet all of the requirements stated below:

- You and your domestic partner are each other’s sole domestic partner and have executed a Declaration of Domestic Partnership or have a California *Certificate of Domestic Partnership*;
- Neither of you is married to or legally separated from another person;
- You and your domestic partner are more than eighteen (18) years old;
- You and your domestic partner are legally competent to contract;
- You and your domestic partner are not related by blood to a degree of closeness which would prohibit legal marriage in the State of California; and

- Any other domestic partnership in which either you or your domestic partner participated must have terminated at least six (6) months prior to the date of signing the Declaration of Domestic Partnership (as described below).

- **Eligibility of Domestic Partners**

Your domestic partner qualifies for coverage as a dependent if he or she meets at least one of the following two eligibility tests:

- **Test #1:** Your domestic partner qualifies for coverage if you have a valid *Certificate of Domestic Partnership* issued by the California Secretary of State pursuant to California Family Law Code § 298. Under California law, you are eligible for such a *Certificate* if you and your **same sex** domestic partner meet the following conditions:
 - Share a place of residence;
 - Are jointly responsible for each other's common welfare and financial obligations; and
 - Are unmarried, legally competent in the State of California to enter into a contract, eighteen (18) years or older, and are not blood relatives.

You and your **opposite sex** domestic partner are eligible for a *Certificate of Domestic Partnership* provided that either you or your domestic partner is over age sixty two (62).

- **Test #2:** If you and your domestic partner are of the **opposite sex** and you are younger than age sixty two (62), the following rules apply:
 - A six-month waiting period will commence from the date of the filing of the initial application for domestic partner coverage during which time your domestic partner is not eligible for benefits;
 - The Plan will provide you with a document, the *Declaration of Domestic Partnership*, which must be notarized and filed with the Administrator's office within thirty (30) days of the filing of the initial application;
 - Within ninety (90) days of the filing of the initial application, evidence of the existence of the domestic partnership must be submitted to the Administrator's Office in the form of two (2) of the following:
 - Proof of joint bank account;
 - Proof of joint lease or mortgage of mutual residence; or
 - A joint billing statement (e.g., utility bill).
 - Upon completion of the six-month waiting period, a Declaration of Reaffirmation of Domestic Partnership must be filed with the Administrator's Office. These forms can be obtained from the Administrator's Office.

Under Test 1 or 2, the Trust Fund reserves the right to obtain your confirmation from year to year that you remain in the domestic partnership registered with the Administrator's Office.

- **Tax Consequences of Domestic Partner Eligibility**

According to the IRS, if your domestic partner is not your “dependent” for federal income tax purposes (*i.e.*, primarily dependent upon you for support *and* residing in your household), the portion of the employer contribution made on your behalf which funds the domestic partner’s coverage is treated as your additional income. The Fund calculates the fair market value of the coverage and reports this amount once annually as your income. Employer taxes attributable to this “income” is paid by the Fund and you must pay the quarterly employee income taxes on the portion of the employer contributions to the Plan determined to be the fair market value of your domestic partner’s coverage.

- **Your Domestic Partner’s Eligibility Date**

(1) Where your domestic partnership is established through a *Certificate of Domestic Partnership* issued by the California Secretary of State your domestic partner’s eligibility (and the eligibility of any children of your domestic partner who qualify for coverage under the terms of the Plan) shall begin on the first day of the month following your enrollment of your domestic partner in the Plan (provided that you remain eligible for coverage as of that date).

(2) If your domestic partner’s eligibility is not based on a *Certificate of Domestic Partnership*, eligibility for your domestic partner and any eligible children of the domestic partner will commence as of the date of the month immediately following completion of the six-month waiting period described above *provided* that you remain eligible for coverage as of that date (see “*Continuing Your Coverage*” above).

Please note that eligibility of a domestic partner and any dependent children will terminate on the earliest of the following dates:

- The date the domestic partnership, as defined by the Plan, terminates;
 - The date a Statement of Termination of Domestic Partnership is signed by either party;
 - The date the covered employee’s eligibility terminates; or
 - The date dependent coverage would otherwise terminate under the terms of the Plan.
- **Benefit Options for Newly Eligible Employees**

When you first become eligible for the Plan, you must select a medical and dental coverage provider.

- **Medical coverage** – You must choose to enroll in one of the three medical options: HMOs Kaiser Permanente or UnitedHealthcare (formerly known as PacifiCare), or the

Fund's Indemnity Plan. If you do not enroll in one of the three options, you will be enrolled in the default option – the Fund's Indemnity Plan.

- **Dental coverage** – You must enroll in one of the following dental options: the DeltaCare DPO, Newport Dental or the Fund's Dental Plan. These options are described beginning on page 36.

Upon attaining Initial Eligibility you will be automatically enrolled with the providers of the following types of coverage:

- Prescription drug coverage (through CVS Caremark) – However, if you enroll in the UnitedHealthcare medical option your prescription drug coverage is through UnitedHealthcare.
- Vision coverage (through the Vision Service Plan)
- Employee Life Insurance
- Dependent Life Insurance (if applicable for your spouse and/or eligible children)
- Accidental Death & Dismemberment (“AD&D”) Insurance
- **Annual Open Enrollment**

After you have completed your first twelve (12) months of coverage, you will have the opportunity to change your medical option during the Plan's annual Open Enrollment. You may change your dental option during any Open Enrollment period.

Open Enrollment is traditionally held during July and any changes become effective August 1 (although the Board of Trustees may change the Open Enrollment period in any given year). You will receive a notice, normally in June of each year, of your options to change and instructions regarding how to secure enrollment literature and change forms. A packet explaining your options and containing a change request form will be sent to you upon your request to the Fund Administrator's Office (therefore, you must send the Administrator's Office a change of address form whenever you change your address).

If you do not send a written change request during Open Enrollment, your existing medical and dental options will be continued for the next benefit year (August 1 through July 31 or the next Open Enrollment, whichever occurs first) and are not subject to change until the next Open Enrollment. This is subject to one exception: Under state law you must live *or* work within fifteen (15) miles or thirty (30) minutes of an HMO hospital and doctor. If you are enrolled in the Kaiser or UnitedHealthcare HMO and move to an area over 30 minutes or 15 miles from the nearest Kaiser facility or UnitedHealthcare contract hospital or doctor you can change your medical option outside of Open Enrollment.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Court Order (“QMCSO”) issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, the Fund will conform to the order for each month in which you are eligible for coverage. A medical child support order is not “qualified” unless it includes all of the following:

- Name and last known address of the parent who is covered under this Plan;
- Name and last known address of each child to be covered under this Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Administrator’s Office. Upon receipt, the Administrator will notify you and describe the procedures for determining whether the order is qualified. As a Dependent covered under the Plan pursuant to a QMCSO, your child will be entitled to information that the Plan provides to other beneficiaries under the Employee Retirement Income Security Act’s (“ERISA”) reporting and disclosure rules.

If you do not enroll your child as required by the QMCSO, the Administrator will do so for you.

You may not drop health care coverage for the child(ren) unless you submit written evidence that the child support order is no longer in effect. A copy of the Fund’s procedures for determination of whether a child support order satisfies the requirements of a QMCSO is available on request.

When Coverage Ends

• When Coverage Ends for Plan Participants

Your coverage generally ends on the earliest of the following:

- The date the Plan terminates;
- The end of the month for which the last employer contribution is made on your behalf;
- The date you enter the military, naval or air service on a full-time basis;
- The date your eligibility for coverage ends as described under “*Continuing Your Eligibility*” on page 3;
- The date your employer terminates participation in the Plan; or

- The date you retire, are pensioned, leave voluntarily, or are dismissed from the employment of your employer, or the date you otherwise stop active work for your employer.

In the event you are unable to work because of disability your coverage will continue as follows:

- If your disability is **work-related** your employer may be obligated to continue contributing for your coverage. To determine whether your employer has this obligation, and if so, for how long, see your collective bargaining agreement;
- If (1) your disability is **not work-related**; *or* (2) your disability **is work-related and you remain disabled after you have exhausted any employer-paid extension of coverage**; the Plan will continue your coverage and your family's coverage without employer or employee contribution for up to three (3) months.

- **When Coverage Ends for Dependents**

Coverage for your Dependents generally ends on the *earliest* of the following:

- The date your Dependent ceases to be eligible as a Dependent under the Plan;
- The date your coverage terminates;
- The date your Dependent enters into the military, naval or air service on an active duty, full-time basis;
- The date the Plan terminates, or terminates coverage for Dependents; or
- The date indicated on a Qualified Medical Child Support Order.
- Certificate of Creditable Coverage

When you lose medical, dental and/or vision coverage under the Plan, the Health Insurance Portability and Accountability Act ("HIPAA") requires that you automatically receive a "Certificate of Creditable Coverage" from the Trust Fund that states how long you were continuously covered under the Plan. You will receive this Certificate even if you elect to continue your coverage through COBRA (as described on page 9).

You may need this Certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that existed before you enroll in the new group plan. You may also obtain a Certificate upon request from the Administration Office.

Continuation of Coverage

- **Self Payment**

You may continue your coverage **for up to six (6) months** under the Plan's self payment provision if your coverage ends because you:

- Resign;
- Terminate employment;
- Are laid off; or
- Go on an approved leave of absence.

If, after the six (6) months of coverage by self payment, you (1) have *not* returned to work, *or* become covered under another group health plan (without limitation to a preexisting condition), and (2) did not become entitled to Medicare during the sixty (60) day period immediately preceding your resignation, layoff or retirement, you may continue coverage (except Life and AD&D Insurance) under COBRA (as described in the following section) for the full COBRA period.

Unlike "COBRA" (described below) your Dependents are not entitled to continue coverage though the Plan's self pay option if you decline this self pay option.

The Board of Trustees determines the self payment rates annually. Self payments are due in the Administrator's Office on the first day of the month for which they are intended to provide coverage and delinquent if not paid by the 30th day of the month. If a self payment is delinquent for more than thirty (30) days, your right to continue coverage by self payment will terminate.

- **COBRA**

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that requires the Trust Fund to provide you and your eligible Dependents with the opportunity to continue your health coverage at your expense when your employer-paid health coverage ends. COBRA applies to medical, dental and vision coverage, but not to Life Insurance, AD&D Insurance, loss of time or disability insurance; however, you may convert your Life Insurance coverage to an individual policy as described under "*Conversion to Individual Coverage*" on page 13.

- **Your COBRA "Qualifying Events"**

You become eligible for COBRA when:

- Your employment is terminated; or
- Your work hours are reduced resulting in your loss of coverage (specifically, the failure to work the hours required under the collective bargaining agreement for contributions to be made on your behalf).

If you experience a COBRA Qualifying Event you may elect to continue coverage for yourself and any Dependents enrolled in the Plan prior to your Qualifying Event.

- **Your Dependents' COBRA "Qualifying Events"**

Your Dependents become eligible for COBRA for the following reasons. Please note that your domestic partner and his/her eligible dependents are *not* eligible for COBRA.

- Your employment is terminated;
- Your work hours are reduced resulting in your loss of coverage (specifically, the failure to work the hours required under the collective bargaining agreement for contributions to be made on your behalf);
- You die;
- You divorce your spouse (this is a "qualifying event" for your divorced spouse only – it does not result in a loss of coverage or COBRA "qualifying event" for your Dependent children because they do not lose coverage as a result of your divorce); or
- When your Dependent child ceases to be eligible for coverage under the terms of the Plan (e.g., your child reaches the maximum age limitation, or your child is no longer a full-time student).

If you do not elect COBRA coverage within the 60-day election period, you and/or your Dependents will lose your rights to COBRA coverage.

Note: (1) In the event of your death, your divorce, or your Dependent child's reaching the maximum age allowed for Dependents, your spouse, ex-spouse and/or Dependents' COBRA period lasts up to thirty six (36) months; (2) To choose COBRA coverage, you must be covered under the Plan on the day before the qualifying event. Children born to, adopted by or placed for adoption with you during the period of your COBRA continuation coverage can be added to your COBRA coverage, as can your spouse if you marry during your COBRA coverage period.

- **COBRA Notification Requirement**

If your Plan coverage ends because of your death, termination or reduced hours, you or your Dependents will receive information from the Administration Office regarding your COBRA coverage rights within thirty (30) days of any of these events. You will have sixty (60) days to elect COBRA coverage.

If you divorce or a Dependent is no longer eligible under the Plan's eligibility rules, you or your Dependent must send notice to the Administrator's Office within sixty (60) days of the event that causes loss of coverage.

- **COBRA Coverage Options**

At the time of your COBRA election you have a one time choice between “core only” and “core plus non-core” benefits:

- “Core coverage” includes medical coverage (in the Trust Fund’s Medical Plan or an HMO), prescription drug coverage, and drug and alcohol rehabilitation coverage.
- “Core plus non-core coverage” includes the coverage listed above, plus vision and dental coverage.
- Whether you choose “core plus” or “core” benefits only, the Plan’s COBRA premium is a “comprehensive” – rather than single or family – premium. Therefore, if you or your spouse elect and pay for COBRA coverage, your (or your spouse’s) COBRA election will cover your eligible Dependents. If, however, a Dependent child has a COBRA qualifying event their COBRA premium is the same but will cover only him/herself.

- **COBRA Coverage Period**

COBRA coverage begins on the date you lose health care coverage because of a qualifying event and typically ends eighteen (18) months later. In some instances, COBRA coverage may last up to twenty nine (29) or thirty six (36) months.

- **Cost of COBRA Coverage**

You (and/or your covered Dependents) must pay the full cost of coverage, plus a 2% administrative fee.

If you or a Dependent are disabled and therefore entitled to more than 18-months of COBRA coverage you will pay 150% of the full cost.

The Board of Trustees will determine the COBRA rate annually. The premium rates will not change during the twelve (12) months following a rate change unless the Board revises the Plan, or continuing dependent coverage is terminated because there are no longer any eligible dependents under COBRA coverage.

If you elect COBRA coverage, your initial premiums are due by the 45th day following the election date. The initial premium payment must include the premiums for coverage from the date coverage ended. You must pay additional premiums in monthly installments; however, you will be allowed a 30-day grace period for subsequent monthly premium payments.

Your COBRA coverage will terminate if you do not make your premium payment before this grace period ends.

- **Extended Coverage Due to a Disability**

If you (or a covered Dependent) are deemed “disabled” by the Social Security Administration when you experience your COBRA “qualifying event” you will be allowed to continue COBRA coverage for an additional eleven (11) months. This brings your total COBRA eligibility to twenty nine (29) months.

To be eligible for this additional continued coverage, you (or any affected Dependent) must notify the Administrator:

- Within sixty (60) days following the date Social Security notifies you that you or any affected Dependent are disabled, but
- No later than the end of your 18-month COBRA coverage period.

You or any affected Dependent must also notify the Administrator within thirty (30) days of the determination that you are no longer disabled. The additional COBRA continuation coverage (i.e., coverage beyond the original 18 months) will end if you or any affected Dependent are no longer disabled.

- **Extended Coverage Due to a *Second* Qualifying Event**

If your Dependents have COBRA coverage due to your termination or reduction in hours worked, and another qualifying event (such as your death or a divorce) occurs during the initial 18-month continuation period, your Dependents are entitled to an additional eighteen (18) months of COBRA continuation coverage.

If you become entitled to Medicare either, (1) *after* you have elected COBRA coverage, your Dependents may continue coverage for up to thirty six (36) months from the date of the original qualifying event; or (2) within the eighteen (18) months *before* your termination or reduction in hours, your covered Dependents may continue coverage for up to thirty six (36) months from the date you became entitled to Medicare.

- **Extended Coverage for Plan Participants on Military Leave**

If your employer-paid coverage ends because you are called up for military service on or after December 10, 2004, the Veterans Benefits Improvement Act extends the period during which you can self pay for coverage by an additional six (6) months, for a total of twenty four (24) months of continuation coverage. This extended coverage runs concurrently with any continuation coverage rights under COBRA.

- **When COBRA Coverage Ends**

Your and/or your covered Dependents' COBRA coverage terminates as of the earliest of the following dates:

- The end of the 18-, 29- or 36-month COBRA coverage period;
- The date a COBRA payment is delinquent in excess of thirty (30) days;
- The date your employer terminates its participation in the Plan and its active employees are enrolled in another group health plan;
- The date you or your Dependent becomes covered by another group health plan, unless that plan limits or excludes coverage of a preexisting condition of that person (at the end of any such exclusion or limitation, COBRA coverage will end);
- The date a person on COBRA coverage becomes entitled to Medicare;
- The month that begins thirty (30) days after a disabled person on extended COBRA coverage is no longer disabled; or
- The date the Plan ends.

Keep the Administrator Informed of Address Changes

Keep the Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrator.

Extension of Coverage During a Labor Dispute

You may continue your coverage under the Plan by self payment for up to a maximum of six (6) months during a labor dispute, under the following conditions:

- You make a monthly self payment as determined by the Board of Trustees,
- At least 75% of all eligible individuals elect to continue their coverage during the labor dispute, and
- You do not accept other full-time employment.