THE EAST BAY DRAYAGE DRIVERS SECURITY FUND

PLAN 2016

Summary Plan Description

And

Plan Document

January 2022

Keep this Summary Plan Description and Plan Document for Future Reference

EAST BAY DRAYAGE DRIVERS SECURITY FUND

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To All Plan Participants

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 Plan is intended to lessen the financial burdens of unforeseen illness or injury. Benefits for Retirees are described in a separate booklet. The Board of Trustees of the East Bay Drayage Drivers Security Fund is pleased to provide this description of benefits under Plan 2016.

This booklet is called a Summary Plan Description (SPD) and is both the Summary and the ERISA Plan Document for the East Bay Drayage Drivers Security Fund. Its purpose is to highlight the key features of the Plan as of January 2022. 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. Please note that there is not a separate "full" plan document and the Summary Plan Description and Trust Agreement are the "plan document" under federal law. If you are enrolled in an HMO, such as Kaiser or Anthem Blue Cross, the HMO's Evidence of Coverage will also serve as a plan document describing your benefits. Collective bargaining agreements and federal regulations are also important for Plan administration, benefits and eligibility. Copies of plan documents, your collective bargaining agreement, and HMO Evidence of Coverage will be made available for your review by making a written request to the Trust Fund Office. You may also obtain provider lists (i.e., in-network or "preferred" doctors and hospitals) by making such a request.

If you have any questions about a particular benefit, please contact the Administrator who will provide answers on the telephone on an informal basis. However, no such oral communication is binding on the Board of Trustees. If you want an official written response, you must send your question, in writing, to the Trust Fund Office. You may not rely on oral representations regarding your benefits. Although the Trustees, the Union and other people familiar with the Plan may answer questions about the Plan for you, the Plan is not bound by any inaccurate information they may give.

You have certain rights, including the right to obtain information regarding your Plan, that are guaranteed under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are explained in detail on page 100 of this booklet.

Limitation of Responsibility

Because the Plan described in this booklet is not insured, the benefits are not guaranteed.

Plan 2016 benefits and the premiums required by Kaiser Permanente Health Plan and any other pre-paid benefit providers are payable out of the Trust Fund to the extent the funds are available in the Trust Fund for that purpose. No other funds and no other person, firm, association, corporation or other entity are liable for the payment of benefits.

The Board of Trustees has established this benefit plan based on the information available to them as to the cost of benefits and the contributions which they anticipate receiving under the applicable collective bargaining agreements. The Trustees reserve the right to modify benefits or eligibility rules at any time, or to reduce or even eliminate benefits, if necessary, to maintain the financial soundness of the Plan. Should this occur, you will be notified. The Trustees also reserve the right to terminate this Plan at any time.

The Trustees have the right, in their sole discretion, to interpret the terms and provisions of the Plan and this booklet, the Trust Agreement, and the rules, regulations and procedures of the Plan. Their good faith interpretations thereof are final and binding on Plan participants, their covered dependents and beneficiaries, and any contributing employer.

The Trustees hope to be able to continue to offer extended coverage for retired employees and surviving family members. However, their ability to do so depends on the underlying collective bargaining agreements and economic considerations. As with benefits for all participants, retiree and survivor benefits are not pre-funded and are not "vested," so future economic conditions might require the Trustees to reduce benefits, increase your contributions, or even eliminate the extended coverage provision of the Plan. This may occur before or after a covered person's retirement or death.

An Important Note

This booklet provides a summary of Plan 2016 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, 2022, unless specifically stated otherwise.

Board of Trustees

Foreign Language Notice

This booklet contains a summary in English of your rights and benefits under the East Bay Drayage Drivers Security Fund. If you have any difficulty in understanding any part of this booklet, you may contact Corcoran Administrators, P.O. Box 5030, Walnut Creek, CA 94596, telephone number (855) 263-7242.

Aviso En Español

Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el East Bay Drayage Drivers Security Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Corcoran Administrators, P.O. Box 5030, Walnut Creek, CA 94596, o llamar a los teléfonos (855) 263-7242.

DIRECTORY OF CONTACTS

ORGANIZATION	WEBSITE	PHONE NUMBER
Trust Fund Office	www.ebddsf.com	925-954-1439
Benefit Questions, Eligibility, Forms Enrollment, Plan Documents		855-263-7242
Forms & Enrollment	Local 70 Health & Welfare Office	510-636-0381
ElixirRx Retail Prescription Drug Provider	www.Elixirrx.com	833-656-1506
Utilization Review Program **Pre-Admission Certification**	Anthem Blue Cross	800-274-7767
Kaiser Permanente Membership services	www.kaiserpermanente.org	800-464-4000
DeltaCare DHMO HMO Dental Benefits	www.deltadentalins.com	800-765-6003
Vision Service Plan (VSP) Vision Provider	www.vsp.com	800-877-7195
Teamsters' Assistance Program (TAP) Substance Abuse Provider	www.tap-program.org	510-562-3600
SleepWorks Sleep Apnea Coverage		844-500-0960
Weekly Disability Plan Weekly Disability Benefits	www.ebddsf.com	925-954-1439 855-263-7242
Life & AD&D Insurance Life & Accidental Death/ Dismemberment Benefits	www.ebddsf.com	925-954-1439 855-263-7242
Medicare Social Security Administration	www.medicare.gov	800-772-1213

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General – Information Concerning Plan 2016

The Booklet restates the East Bay Drayage Drivers Security Fund's Plan 2016 as of December 2017. It is the Summary Plan Description (SPD) and the ERISA Plan Document for Plan 2016. The provisions of this Plan are effective as of January 1, 2022, although certain provisions have different effective dates as noted.

The Plan is maintained for the exclusive benefit of Participants and their eligible Dependents. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as that Act applies to multiemployer health and welfare employee benefit plans such as Plan 2016.

Benefits Other Than Medical and Prescription Drugs: The Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

- **Life Insurance and Death Benefit** (through ULLICO);
- **Disability Benefit** (Self-Funded);
- **Vision Care** (through VSP);
- **Sleep Apnea Program** (through SleepWorks);
- **Treatment of Alcohol or Chemical Dependency** (through the Teamsters' Assistance Plan).

Eligibility

Eligibility for you and your eligible family members depends on the number of hours you work in "covered employment."

Covered Employment

Covered employment is how you earn coverage under the Plan. Covered employment includes the following:

- Your work under a collective bargaining agreement between Teamsters Local 70 and an employer who agrees to contribute to the Plan on your behalf.
- Other types of work, including employment with Teamsters Local 70 or for an employer who has signed a "Subscription Agreement" to contribute to the Plan on your behalf. A Subscription Agreement is typically used to cover non-collectively bargained employees who work for a participating employer. Special eligibility provisions may apply under the Subscription Agreement. To learn about any special provisions that may apply to you, call the Trust Fund Office.

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. **NOTE: In the first year of your eligibility, your only option for Medical coverage is under Kaiser. You may change your plan options during the first open enrollment period after you first become eligible for coverage.**

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 nevertheless requires your employer to make contributions on your behalf.

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).

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.

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 another person (an individual who has obtained a legal separation but not a final divorce decree is still considered married for purposes of entering into a new marriage or domestic partnership until the final judgment is entered);
- You and your domestic partner are more than eighteen (18) years old;
- You and your domestic partner are legally competent to contract marriage or domestic partnership;
- 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).

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" are 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.

Benefits Summary

This Benefits Summary is intended as an "at a glance" description of benefits. For a complete explanation of the benefit and any limitations, see the part of this booklet that addresses that benefit.

THE SELF-FUNDED MEDICAL PLAN

	PPO NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Deductible Individual	$250	$500
Deductible Family	$500	$1000
	Note: The In and Out of Network Deductible is applied separately; no crossover	
Annual Out-of-Pocket Maximum	$2,500/$5,000 After Deductible	$5,000/$10,000 **After Deductible**
	Note: The Out of Pocket maximum excludes penalties	
LIFETIME MAXIMUM	There is no Lifetime maximum	There is no Lifetime maximum
ANNUAL MAXIMUM	There is no Annual maximum	There is no Annual maximum
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES***
Physician Services – Office Visits	$15 Copay 80% of PPO Rate	60% of Usual Customary and Reasonable (UCR)
Preventive Care	100% of PPO Rate (deductible waived)	60% of UCR
Hospital/Surgical Services	80% of PPO Rate	60% of UCR
Prescription Drugs-ElixirRx **Generic** **Brand**	No Deductible or Copay Brand Name and Generics Covered at 100%	Out of Network Prescriptions Not Covered

Kaiser HMO BENEFITS CHART

HMO Services	Kaiser Permanente	
Providers	Must use Kaiser providers	
Annual Deductible	None	
Annual Out-of-Pocket Maximum	One person: $1,500 Family: $3,000	
Lifetime Maximum	None	
Hospitalization	No Cost Share	
Doctor Office Visits	$5 per visit	
Preventive Care	No Cost Share	
Ambulance Services	No Cost Share	
Emergency Room	$5 per visit	
Prescription Drug	Generic or Brand Name Drugs: $5 Co-pay for up to 100 day supply	

DENTAL BENEFITS CHART

Dental Services	DeltaCare
Providers	Must use DeltaCare USA dentists
Annual Deductible	None
Annual Out-of- Pocket Maximum	None
Annual Maximum	None
Lifetime Maximum	None (except Orthodontia)
Percentage of Claims Covered	Paid in full (subject to the limitations and exclusions of the benefit schedule)

VISION BENEFITS

Through **Vision Service Plan** ("VSP")

If you use a VSP Provider:	If you use a Non-VSP Provider:
▪ No copayment ▪ Exams – once in any 12 months ▪ Frames – one pair in any 24 months – up to $195 and 20% off the amount over $195 ▪ Lenses – one pair in any 12 months – paid in full ▪ Contacts in lieu of glasses – one pair in any 12 months – up to $105 per pair and payment for lens exam (fitting and evaluation)	▪ No copayment ▪ Exams – Once in any 12 months – up to $45 ▪ Frames – Once every 24 months – up to $75 ▪ Lenses – Single vision – up to $45 per pair – Lined bifocal – up to $65 per pair – Trifocal – up to $85 per pair ▪ Contacts – up to $105

SUBSTANCE ABUSE TREATMENT

Applies to ALL Plan participants, including HMO enrollees.	100% coverage in a Teamsters' Assistance Program (PPO) approved facility or 80% of UCR in a Non-PPO facility Subject to pre-authorization by TAP for inpatient care

DISABILITY BENEFITS

Self-Funded Disability Benefits	$40 per week, maximum of 26 weeks for Employee only

LIFE AND AD&D INSURANCE

Through **Union Labor Life Insurance Company**	Employee: $25,000 life insurance and up to $25,000 AD&D Dependent: Spouse – $12,500 (life only); Child over 6 months through age 20 – $1,000 (life only); Child under 6 months – $100

How to Enroll

FOR ALL PLAN PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Coverage for yourself and your eligible dependents begins on the first day of the month in which you initially become eligible for benefits or regain eligibility for benefits.

Initial Eligibility

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 two medical options: Kaiser Permanente HMO, or the Self-Funded Plan. In the first year of your eligibility, your only option for Medical coverage is under Kaiser. You may change your plan options during the first open enrollment period after you first become eligible for coverage. If you have not enrolled before, or you are changing Medical Plans, be sure to complete the entire box marked "CHOICE OF PLANS." If you do not enroll in one of the two options, you will be enrolled in the default option – the Kaiser HMO Plan.
- **Dental coverage** – You must enroll in one of the following dental plan, the DeltaCare DPO. This option is described beginning on page 43.

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

- Prescription drug coverage (through ElixirRx for Self-Funded Plan participants) – Participants enrolled in Kaiser receive their prescription drug coverage through Kaiser.
- Vision coverage (through the Vision Service Plan)
- Substance Abuse Treatment Plan
- Employee Life Insurance and Dependent Life Insurance (if applicable for your spouse and/or eligible children)
- Accidental Death & Dismemberment ("AD&D") Insurance

Enrolling New Dependents

Before allowing a dependent to be added to the Plan, the Trust Fund Office will require documentation such as a marriage certificate, birth certificate, divorce, or remarriage documents.

Newly acquired eligible dependents, including a new spouse, newborn or stepchild, will be covered from the time of birth, adoption or marriage, provided you complete and submit an enrollment form and appropriate documentation as required *within 60 days of birth, adoption or marriage*. If you enroll your eligible dependent *after* 60 days, coverage for that dependent will be effective the first day of the month in which the dependent is enrolled in the Plan.

Claims for dependents cannot be processed until an enrollment form and proper documentation are received by the Trust Fund Office.

Notification of Change of Address

From time to time, the Trust Fund Office will need to write to you to inform you of changes in the Plan adopted by the Trustees or about information related to your benefits.

In these instances, the Plan will try to make sure that you receive the written notices. However, if you move or change your mailing address or if you think the Trust Fund Office does not have your current address, you must notify the Trust Fund Office, in writing, of the change of address immediately. The Plan and the Trustees cannot be held liable for not keeping you informed if you change your address and do not notify the Trust Fund Office in a timely manner.

DESIGNATION OF BENEFICIARY

You must complete a beneficiary card at the time of initial enrollment in the Life Insurance and Accidental Death and Dismemberment (AD&D") plans). If you decide to change your beneficiary, you must complete a new beneficiary card.

Medical Benefits

Self-Funded Plan Benefit Summary

The Health Care Plan helps pay eligible expenses each calendar year. For more details, see the pages which follow the chart.

The following chart summarizes your medical benefits.

	PPO PROVIDERS	OUT-OF-NETWORK PROVIDERS
Deductible Individual	**$250**	**$500**
Deductible Family	**$500**	**$1000**
	NOTE: You may carry over any covered charges applied toward the deductible in the last ninety (90) days of a calendar year to satisfy the deductible for the following calendar year. However, your coinsurance (the percentage of covered charges which you are required to pay) may not be used to satisfy the deductible.	
Annual Out-of-Pocket Maximum	**$2,500/$5,000 after Deductible**	**$5,000/$10,000** **If you use a Non-PPO Hospital for reasons other than an Emergency** Claims are paid at 60% of UCR charges and the 40% you pay will **not** be applied to your Annual Out-of-Pocket Maximum, **except**, o If there is no PPO Hospital within thirty-five (35) miles of your residence or the site of your injury, or o If you file a written request for waiver with the Fund Office and a waiver is deemed valid by the Administrative Office based on your request. This waiver is applicable only once in a Participant or Dependent's lifetime. If either of these two exceptions apply, a Non-PPO Hospital claim will be paid at 80% of UCR charges subject to the Annual Out-of-Pocket Maximum (after the deductible is satisfied).
LIFETIME MAXIMUM	**There is no Lifetime maximum**	**There is no Lifetime maximum**
ANNUAL MAXIMUM	**There is no Annual maximum**	**There is no Annual maximum**
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES***
Physician Services		
Office Visits	**$15 Copay/visit then 80% of PPO Rate**	**60% of UCR**
Second Opinions	**100% of PPO Rate**	**100% of UCR**
Hospital/Skilled Nursing Visits	**80% of PPO Rate**	**60% of UCR**
Specialists	**$15 Copay visit then 80% of PPO Rate**	**60% of UCR**
Surgeon/Asst. Surgeon	**80% of PPO Rate**	**60% of UCR**
Anesthesiologist	**80% of PPO Rate**	**60% of UCR**
Diagnostic X-ray & Labs	**$15 Copay/visit then 80% of PPO Rate**	**60% of UCR**
Preventive Care		
Routine Physical Exam	**100% of PPO Rate (deductible waived)**	**60% of UCR**
Well Baby Care	**100% of PPO Rate (deductible waived)**	**60% of UCR**

Immunizations	100% of PPO Rate (deductible waived)	60% of UCR
Hospital/Surgical Services		
Inpatient **Limited to 365 days per Hospital Confinement**	**80% of PPO Rate**	**60% of UCR**
Outpatient	**80% of PPO Rate**	**60% of UCR**
Emergency Services		
Ambulance	**80% of PPO Rate**	**80% of UCR**
Urgent Care	**$50 Copay (deductible waived)**	**60% after deductible**
Emergency Room No Admission	**$100 ER Copay then 80% of PPO Rate**	**$100 ER Copay then 80% of UCR**
Emergency Room (admission)	**80% after Deductible**	**80% after Deductible**
Maternity Services	**80% of PPO Rate**	**60% of UCR**
Chiropractic Services	**$15 Copay 80% of PPO Rate**	**60% of UCR**
Continued Care Services		
Home Health Care	**80% of PPO Rate**	**60% of UCR**
Skilled Nursing Facility	**80% of PPO Rate**	**60% of UCR**
Physical Therapy	**$15 Copay 80% of PPO Rate**	**60% of UCR**
Durable Medical Equipment	**80% of PPO Rate (up to $10K per year)**	**60% of UCR**
Services listed under the heading *"Other Frequently Utilized Medical Services"* on page 30	**80% of PPO Rate**	**60% of UCR**
		* you may have additional out-of-pocket costs if charges exceed UCR

How Your Medical Benefits Work

The Plan helps you pay each covered person's eligible expenses which are:

- medically necessary,
- prescribed by a doctor,
- within the reasonable and customary limits, and
- covered by the Plan.

For the most part, you can see any doctor and receive treatment at any hospital that you choose. However, the Plan utilizes a Preferred Provider Organization (PPO) through Anthem Blue Cross for medical care which extends reduced rates to the Plan. In addition to receiving the benefits of these reduced rates, the Plan also pays a higher percentage of the cost of many services for PPO network providers than for non-PPO (non-network) providers. Thus, you will generally pay more from your own pocket when you use a non-network provider and are therefore encouraged to use PPO providers whenever possible.

How the Self-Insured Medical Plan Works

The Medical Plan provides comprehensive medical coverage when you are diagnosed and treated for a non-occupational illness or accidental injury.

Your out-of-pocket charges under the Medical Plan are based on three factors:

(1) Have you satisfied the annual individual and family medical deductible?

(2) Have you satisfied your Annual Out-of-Pocket Maximum (if applicable)? and

(3) (For many benefits) Have you used a PPO Hospital, facility, or doctor or a Non-PPO Hospital, facility or doctor?

Coverage Terms Under the Self-Insured Medical Plan in Relation to PPO Contracts and Medicare

If a PPO ("preferred provider organization") Network agreement to which the East Bay Drayage Drivers Fund is also signatory or Medicare (for a Medicare-eligible Plan participant or dependent) impose coverage terms that materially differ from the terms of the Plan described in this Summary Plan Description, the PPO agreement or Medicare rules will control how this Plan will cover, process, and pay the claim. This includes, but is not limited to, applicable time limits for processing claims and requirements regarding prior-authorization and utilization review.

Eligible Expenses

The Plan helps pay eligible expenses that are determined to be all of the following:

- **Medically Necessary** as defined on page 116.
- **Prescribed by a Doctor** who is a licensed practitioner of medicine or surgery who is acting within the scope of his/her practice and license.
- **Usual, Customary and Reasonable (UCR)** as defined on page 122. If you would like to know the UCR the Plan will apply to a treatment, service or supply, you must submit a written request to the Trust Fund Office.

  When you use a contract hospital or a preferred doctor, the eligible expenses are based on a negotiated rate. When you use a non-PPO provider, the Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable deductible, copay and/or coinsurance. This is because, unless otherwise provided, the Plan covers only the UCR amount for health care services or supplies. Any amount in excess of the UCR amount does not count toward the Plan's annual out-of-pocket maximum. You are responsible for paying any billed amounts that exceed the UCR amounts. The Plan reserves the right to negotiate with a non-PPO provider to reduce its charges.

- **Covered by The Plan.** Services and supplies not covered are listed on pages 33-35.

How Benefits Are Determined

As shown in the **Benefits Summary** above, there are a few types of payment provisions you should be aware of when determining how much the Medical Plan pays and how much you must pay for covered services: deductibles, out-of- pocket maximums, and lifetime maximums.

- **Deductible**

The deductible is the amount you must pay each calendar year before the Plan begins to pay benefits. There is an individual deductible and a family deductible. Once you have satisfied your deductible, the coinsurance amounts (as described below) will apply, unless otherwise noted.

The deductible applies separately to you and each of your covered family members. However, the Plan includes two features that may reduce your deductible expenses for the year: the family maximum and the annual carryover.

1. **Family Maximum** – Although the annual deductible applies separately to each person, it is limited to $500 annually per family when using in-network providers and $1,000 annually per family when using out of network providers. The following example illustrates how this works for Joe and his family using in-network providers. A family is defined as two or more people.

Family Members	Eligible Expenses
Joe	$250 (the full $250 satisfies his individual deductible)
Wife Sally	$95
Daughter Sue	$55
Son Frank	$70
Daughter Linda	$30
	$500

   This family has met its deductible family maximum. As you can see, no more than $250 in eligible expenses for any person can be applied toward the family maximum, but not everyone needs to satisfy it individually. The Plan helps pay all the covered family members' eligible expenses that occur after the family maximum has been met.

2. **Annual Carryover** – Any eligible expenses you have in October, November or December that are applied toward the deductible for that year are carried over and also applied toward the deductible for the next year. This way, if you have deductible expenses in the last three months of a year, you will be credited for them in the following year.

Note that the following types of out-of- pocket costs will not be applied toward your annual deductible:

1. Charges for services or treatment not covered by the Plan; and/or

2. Amounts in excess of the Usual, Customary and Reasonable ("UCR") Charges.

- **Coinsurance**

"Coinsurance" is the percentage of covered expenses paid after you satisfy any applicable deductible and before you reach the annual out-of-pocket maximum. Note that for Out-of-Network providers the "covered expenses" are based on UCR charges; any charges above these amounts are your responsibility and are not part of the amount subject to coinsurance.

The coinsurance percentages apply until you reach your annual out-of-pocket maximum, at which point the Plan pays 100% of covered expenses for the rest of the calendar year.

- **Out-of-Pocket Maximum**

The out-of-pocket maximum is the maximum amount (in addition to the deductible) you should pay toward your covered benefits each calendar year. Under the Self-Funded Medical Plan, the out-of-pocket maximum is $800 per covered individual.

Your annual out-of-pocket maximum does **not** include:

- Deductibles;
- Charges for services or treatment not covered by the Plan; or
- For Non-PPO Hospitals, Doctors and other providers, charges in excess of covered expenses. Generally, this means that Hospital charges in excess of what the Plan determines to be Usual, Customary and Reasonable ("UCR") is not subject to your annual out-of-pocket maximum.

Once the out-of-pocket maximum is reached, the Plan pays all of your and your eligible dependents' additional eligible expenses for the rest of the year.

- **Choice of Hospital**

You may use any licensed doctor or hospital you choose. However, how your hospital claim will be paid depends on whether you use a "PPO" or "Non-PPO" hospital. The term "PPO" means "preferred provider organization" and refers to a network of hospitals and doctors that have contracted with the Plan's PPO provider.

  - If you have **inpatient surgery, lab tests or X-rays, or an inpatient stay at a PPO hospital** or **you have outpatient surgery at a PPO hospital,** the Plan pays in full for all facility charges and services and these services are NOT subject to satisfaction of the annual deductible.

  - For **outpatient services other than surgery, lab tests, or X-rays at a PPO hospital**, the annual deductible applies. The Plan pays 80% of the PPO hospital charges (and 100% after you have satisfied the Plan's annual $800 out-of-pocket maximum).

- If you have **inpatient surgery, outpatient surgery, or an inpatient stay at a Non-PPO hospital,** the Plan pays 60% of Usual, Customary and Reasonable ("UCR") charges. Pre-Admission Certification

"Pre-Admission Certification" is a utilization review process which certifies the medical necessity and length of stay for any hospital confinement. **Pre-admission certification is required for all non-emergency hospital admissions.**

To complete the pre-admission certification process, you (or your medical provider) must notify the Trust Fund's Review Organization (ANTHEM BLUE CROSS) prior to any hospital admission by calling (800) 274-7767.

Pre-admission certification only determines the **medical necessity** of a service or supply according to the Plan benefits and provisions: it does not determine whether the treatment is **covered by the Plan. The fact that a hospitalization has been pre-admission certified does not mean the service or supply is fully or even partially covered.** To be covered, the hospitalization must also qualify as a covered expense. See "What the Medical Plan Covers" below.

For **Emergency Admissions,** you must contact ANTHEM BLUE CROSS at the number listed above within seventy-two hours of your admission.

- **Lifetime Maximum**

There is no general lifetime maximum for the Self-Funded Medical Plan.

The Plan retains a separate lifetime maximum for treatment of infertility, which is $25,000 per couple.

Preferred Provider Network

The Board of Trustees has selected the Anthem Blue Cross Preferred Provider Network. Anthem Blue Cross negotiates with qualified doctors, hospitals, and laboratories to provide treatment and services at special contract rates to Plan participants and their eligible dependents.

How to Find a Preferred Doctor or Hospital

You maximize your benefits if you use a preferred provider (doctor or hospital). See page 11 for a summary of the differences in what the Plan pays for use of PPO providers versus non-PPO providers.

To find a Doctor or Hospital in the Anthem Blue Cross Network, register online at *www.anthem.com*, or call the Administration Office at (925) 954-1439 or (855) 263-7242.

When you seek treatment from a physician, please contact Anthem Blue Cross before setting up an appointment to confirm that the particular practice is a PPO provider. Please be aware that a doctor listed as a PPO physician in the Anthem Blue Cross network may also have practices that are not PPO.

Preferred Provider Network for Out-of-State Members – BlueCard Program

If you reside or travel outside the state of California, you will have access to providers who participate in a "Host Plan" that participates in the BlueCard Program. Please see Out of Area Program on page 19 for additional information about coverage outside of California.

How to Use the Preferred Provider Network in California

Each time you need medical care, you may choose any doctor or facility in the Preferred Provider Network in California. When you use a provider in your area, keep these important points in mind:

1. When you call for an appointment, indicate that your coverage is through the East Bay Drayage Drivers Security Fund Plan #2016 and you are using the Preferred Provider Network managed by the Anthem Blue Cross.

2. When you receive treatment or services, do not pay the doctor or hospital – the provider will bill the full amount for their services directly to the Trust Fund. The Trust Fund will inform you of any expenses you must pay by sending you an *Explanation of Benefits*.

3. Your *Explanation of Benefits* will indicate:

   (a) Any eligible expenses you are required to pay the provider.

   (b) Expenses the Plan has paid to the provider.

   (c) The amount by which the provider has agreed to discount his/her fees which is not charged to the participant.

4. Your eligible expenses are at the special contract rate – not the regular fee charged. You are not responsible for paying the provider's fees without the PPO discount. If the provider accidentally bills you for the full amount, simply send the provider a copy of the Explanation of Benefits.

5. If you have any questions or comments regarding your visit to a provider, or about expenses charged to you, call the Trust Fund Office.

Contract (PPO) Hospitals

When you or an eligible dependent is hospitalized, the Plan benefit depends on whether the hospital is a "contract" or PPO hospital. If you use a PPO hospital, your out-of-pocket cost will be substantially less.

If you do not use a contract hospital, the Plan will pay its portion of the "Usual, Customary and Reasonable" (UCR) charges, subject to "Utilization Review". You will pay the remainder, and those payments will not count toward your out-of-pocket maximum.

If you are admitted to a non-contract hospital, and Anthem Blue Cross certifies the admission as an emergency or "referral" admission, the Plan will pay the in-network coverage percentage of UCR charges, until Anthem Blue Cross determines that the patient is stabilized and can safely be transferred to a contract hospital.

A "referral admission" is when you are admitted to a non-contract hospital when the medically necessary services cannot be rendered in a contract hospital within a 30-mile radius of your residence.

Designation of a Primary Care Physician (PCP) Not Required

The Indemnity Medical Plan does not require the selection or designation of a primary care Physician (a "PCP"). You have the ability to visit any network or non-network health care provider; however, **the Plan will pay less of the bill from a non-PPO Network hospital or doctor than it will for a PPO Network hospital or doctor.**

You do not need prior authorization and/or a referral from the Plan or from any other person (including a primary care Physician) to receive care from a health care professional who specializes in obstetrics or gynecology. However, the health care professional may be required to obtain prior authorization for certain services described in this booklet and follow a pre-approved treatment plan, or procedures for making referrals.

Outpatient Surgical Center

When you or an eligible dependent require outpatient surgery, the Plan benefit depends on whether or not the outpatient surgical center is a PPO facility.

When you use a PPO surgical center, the Plan will pay 80% of the negotiated contract rate, subject to Utilization Review. When you use a non-PPO facility, the Plan will pay 60% of UCR charges, subject to Utilization Review.

Differences in PPO Contracts

From time-to-time the PPO contract with a hospital or medical provider may provide for payment of a claim under different terms than are described in this booklet. If the Board of Trustees concludes that the Plan is required to process and/or pay the claim as provided in that contract rather than as described here, the Plan reserves the right to process and/or pay the claim as the contract requires.

Out of Area Program

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Plan calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this Summary Plan Description (SPD). When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See BlueCard Program in this section of this booklet.

Anthem Blue Cross of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Plan's payment practices in both instances are described in this SPD.

If you do not see a Participating Provider through the BlueCard Program, you may have to pay the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Plan for payment. The Plan will notify you of its determination within 30 days after receipt of the claim. The Plan will pay you at the Non-Preferred Provider Benefit level. Remember, your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Plan and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in Copayment calculations or in calculation of the out-of-pocket maximum.

To receive the maximum benefit, please follow the procedure below.

When you require Covered Services while traveling outside of California:

1. Call *BlueCard Access®* at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or consult the website www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,

2. Visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Covered Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Plan will cover services received for emergency care of an illness or injury anywhere in the world.

BLUECARD PROGRAM

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits SPD). However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment and deductible amounts, if any, as stated in this SPD.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Anthem Blue Cross of California.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this SPD.

Description of Covered Medical Services

What the Medical Plan Covers

The following is a summary of covered services, and the benefits that are paid for these services. Keep in mind that services or supplies are not covered unless prescribed by a physician and necessary for the care and treatment of an injury or a sickness (unless the covered service listed is specifically for preventive care).

REMEMBER – For purposes of the Medical Plan benefits, the percentage payable – 100% or 80% in most cases – assumes that you have not yet reached your annual out-of- pocket maximum (generally $800). For many Medical Plan benefits, once you have paid your deductible and your annual out-of-pocket maximum, your claim will be paid at either 100% of the PPO rate (if you use a PPO provider) or 100% of Usual, Customary and Reasonable ("UCR") charges if you use a non-PPO provider.

This information is divided into the following major categories:

- At the Doctor's Office
- Maternity Services
- At the Hospital
- Surgery
- Supplemental Accident Benefits
- Organ Transplants
- Other Frequently Utilized Medical Services

For a description of the prescription drug benefits available under the Self-Funded Medical Plan, see *"Prescription Drug Benefits"* on page 35.

- **At the Doctor's Office**

In addition to the Physician's/Doctor's Office benefits listed in the *"Benefits Summary"* above on pages 11-12, please note the following about your Doctor's Office benefit:

Routine Physical Exam

To encourage preventative health care, the Plan covers routine physical examinations provided by a doctor of medicine or doctor of osteopathy, including gynecological examinations and, if required, electro-cardiograms.

Routine Physical Exams are covered at 100% of covered charges at a PPO facility and 60% of UCR at a non-PPO facility. The Plan will cover the following preventive services without you having to pay copayment or coinsurance or meet your deductible, when these services are recommended for your age and gender by the U.S. Preventive Services Taskforce. You can get more information, including a list of current recommended preventive services by visiting: https://www.healthcare.gov/coverage/preventive-care-benefits/

Covered Preventive Services for Adults:

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked

- **Alcohol Misuse** screening and counseling
- **Allergy** testing
- **Annual Adult Routine Physical Exam**
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at a higher risk for chronic disease
- **Hepatitis B screening** for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- **Hepatitis C screening** for adults at increased risk, and one time for everyone born 1945 – 1965
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults –doses, recommended ages, and recommended populations vary:
  Hepatitis A
  Hepatitis B
  Herpes Zoster
  Human Papillomavirus
  Influenza (Flu Shot)
  Measles, Mumps, Rubella
  Meningococcal
  Pneumococcal
  Tetanus, Diphtheria, Pertussis
  Varicella
- **Lung cancer screening** for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Syphilis** screening for all adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women:

- **Anemia** screening on a routine basis for pregnant women
- **Breast cancer genetic test counseling (BRCA)** for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).

- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational Diabetes** screening for women 24 to 48 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Gynecological** routine exam and Pap Smear
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** intervention and counseling for all women, and expanding counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Urinary tract** or other infection screening
- **Well-woman Visits** to obtain recommended preventive services

Covered Preventive Services for Children:

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages (Covered services vary for ages 0-17)
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight, and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **Hepatitis B screening** for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years
- **HIV** screening for adolescents at higher risk
- **Hypothyroidism screening** for newborns
- **Immunization** vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
  Diphtheria, Tetanus, Pertussis
  Haemophilus influenza type b
  Hepatitis A
  Hepatitis B
  Human Papillomavirus

Inactivated Poliovirus
Influenza (Flu Shot)
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Rotavirus
Varicella (Chickenpox)

- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

Outpatient Laboratory and Radiology

After your deductible, charges for diagnosis or treatment by a radiologist or laboratory are paid at 80% of the contract rate, if you use a PPO provider. Non-PPO providers are paid at 80% of UCR charges.

Chiropractic Care

Charges incurred for chiropractic treatment will incur a $15/copayment per visit and then will be paid at 80% of covered charges for PPO providers and 60% of UCR for non-PPO providers. The initial chiropractic consultation and X-rays are covered the same as any other medical treatment. Covered Medical Chiropractic Expenses include the following procedures:

(1) Spinal manipulation;
(2) Adjunctive therapy;
(3) Vertebral alignment; and
(4) Spinal column adjustments.

Mental Health Care (Inpatient and Outpatient)

The Plan pays benefits for treatment of mental illness or functional mental disorders when provided by a Doctor of Medicine (M.D.), or a licensed psychologist; or with a physician referral and supervision by the M.D., a Master of Social Work, or licensed therapist.

Diagnostic and Therapy Services

The following items are paid at 80% of the contract rate for PPO providers with a $15 copay and 60% of UCR charges for non-PPO providers.

1. **X-ray, radium and radioactive isotope therapy**

2. **Outpatient physical therapy**

3. **Outpatient occupational therapy**

4. **Speech therapy –** services of a speech therapist:

   The services of the therapist must be recommended by a qualified physician, as defined in the Plan, who continues to control and direct the overall treatment of the case. In addition, there must be an expectation that the therapy will result in a significant improvement of the specific speech defect.

   Speech therapist services will be covered if all the above requirements are met and:

   (a) The services of a speech therapist are required to restore normal speech which was impaired or lost due to illness or non-occupational injury, such as following a stroke or laryngectomy (not for a congenital condition such as mental retardation or cleft palate). Restorative speech therapy services are subject to utilization review when such services extend beyond a thirty (30) day period of treatment; or

   (b) The services of a speech therapist are required due to a developmental delay such as autism. All speech therapy services for developmental delays are subject to utilization review.

5. **Infertility**—diagnosis and therapy to determine the cause of infertility, the surgical or hormonal treatment to correct the physical problem, and the treatment to directly help you conceive or become pregnant (such as in-vitro fertilization or artificial insemination). The Plan retains a separate lifetime maximum for treatment of infertility, which is $25,000 per couple.

6. **Therapy for Autism Spectrum Disorder** - Treatment for Autism Spectrum Disorder ("ASD"), including Applied Behavior Analysis ("ABA") and Applied Behavior Therapy ("ABT"), is covered subject to the same conditions that apply to other kinds of outpatient therapy, including deductibles, co-pays, co-insurance review for medical necessity, and other medical management. Please note that if your Autism provider is not in the PPO network your out-of-pocket costs are likely to be much higher.

- **Maternity Services**

Office Visits

Each visit will require a $15 copayment. After copay, the Plan pays 80% of covered facility charges after the deductible.

Hospital Services

The Plan pays 80% of covered charges.

Note: In accordance with federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- Forty-eight (48) hours following a normal (vaginal) delivery, or
- Ninety-six (96) hours following cesarean section.

However, federal law does not prohibit a hospital or doctor from discharging the mother or newborn earlier with the mother's consent. In addition, the Plan may not require that a provider obtain pre-

authorization to prescribe a length of stay that does not exceed the periods (48 or 96 hours) outlined above.

Hospital Expense

In addition to the Hospital office benefits listed in the "Benefits Summary" above on pages 11-12, please note the following about your Hospital benefit:

When you or your covered dependent is confined to a hospital as a registered bed patient as the result of an injury or illness, the Plan will pay a portion of hospital room and board and miscellaneous hospital expenses (which include items such as the operating room, supplies and drugs used while you are confined, X-rays and lab tests and radiation, physical, speech or occupational therapy) as follows:

1. If you use a contract (PPO) hospital, the Plan will pay 100% of the negotiated rate for hospital services (this includes both room and board and miscellaneous hospital charges), subject to Utilization Review through Anthem Blue Cross.

2. If you use a non-PPO hospital, the Plan will pay hospital room and board and miscellaneous hospital charges at a rate of 80% of UCR, subject to Utilization Review.

Personal items such as television rental or guest meals are not covered by the Plan.

For **inpatient hospitalizations**, Hospital room and board is covered at the standard semi-private room rate or, when medically necessary, in an intensive care unit ("ICU"), a cardiac care unit ("CCU"), or similar specialized unit or room.

Emergency admissions are treated and payable as contract hospital admissions. The Plan covers emergency services provided in a hospital emergency room without prior authorization. The Plan currently covers 100% of the contract rate for emergency services received from a PPO provider, and 100% of the Usual, Customary and Reasonable charges for emergency services received from a non-network provider.

For **Convalescent Hospitals**, room and board for up to sixty (60) days at the Convalescent Hospital's standard semi-private room rate, but only while confined as a registered bed patient. Confinement will not be covered unless it begins within seven (7) days following termination of a Hospital Confinement of at least five (5) days. All periods of Convalescent Hospital confinement during any disability will be considered one confinement.

Case Management / Transitional Care

In some instances, a patient's needs may be met as well or better by offering an alternative to an acute care hospital confinement or other type of care. Such alternatives include home health, hospice, or skilled nursing facility care. In appropriate cases, working with the patient's own physician, the case management program assesses whether an alternative treatment is suitable for the individual patient and helps ensure that the health care services are coordinated and carried out in a manner that ensures continuity and quality of care.

The alternative treatment programs will pay benefits only on expenses incurred for these programs that have been arranged and pre-approved by Anthem Blue Cross and are covered by this Plan.

The Plan has contracted with Anthem Blue Cross to provide Case Management in the transition from an acute hospital stay to one of the following levels of care: Home Health Care, Hospice Care, and Skilled Nursing Care. For more information, call Anthem Blue Cross at (800) 274-7767.

Home Health Care

Home Health Care is covered, up to 80% of the contract rate if you use a PPO provider, or 60% of UCR for non-PPO providers, subject to preauthorization. Custodial care and services are not covered by the Plan. Services are covered for up to a maximum of ninety (90) days following discharge from a Hospital or Convalescent Hospital if provided in the individual's home by a home health care agency.

Hospice Care

Hospice Care services encourage the caregivers and patients to consider palliative care (the treatment to relieve pain or suffering) as an alternative to more aggressive treatment. Hospice care benefits are paid at 80% of the in-network allowed rate and 60% of UCR for services incurred out of network. Hospice care is covered up to 180 days of inpatient care provided in a hospice facility or outpatient care provided at the patient's home. The following inpatient and home care Hospice services will be covered:

- daily hospice room and board or care given at the home
- use of medical equipment
- homemaker services
- counseling services

Hospice Counseling

Hospice counseling is covered up to $750 per family. Bereavement counseling is covered up to $250 per family (when used within three (3) months after the death of the covered family member). Other related services and other charges made by a hospice care agency may also be covered if provided as part of a Hospice care program.

Skilled Nursing Facility

A Skilled Nursing Facility is either a nursing home with skilled nursing care, a convalescent hospital, or a special hospital wing for convalescent patients, provided they are organized and operated in accordance with applicable laws. **Admission to a Skilled Nursing Facility requires pre-authorization.**

For PPO providers, the Plan pays benefits at 80% of the negotiated rate for room and board. For non-PPO providers, the Plan pays at 60% of UCR for room and board up to 100 days per calendar year provided while the individual is confined following an illness, injury or hospitalization.

Miscellaneous charges at a Skilled Nursing Facility are covered at 60% of UCR, provided they meet all other Plan rules for eligible expenses and are not for custodial care.

Surgeon's, Physician's and Anesthesiologist's Fees

The Plan covers elective and Emergency Surgery. For non-emergency surgery, preadmission certification (as described on page 15) is recommended.

Surgeon's fees and physician's fees are paid at 80% of the contract rate, if a preferred provider is used. The fees of an anesthesiologist are paid at 80% of UCR regardless of whether he or she is a PPO or non-PPO provider, as long as the surgeon and hospital are PPO providers.

Fees charged by surgeons and physicians who are non-PPO providers are paid at 80% of UCR charges. In addition, the services of non-PPO physicians, surgeons and assistant surgeons, as well as any lab work or diagnostic testing, rendered in an emergency as defined by the Plan, will be paid up to 80% of UCR regardless of whether the provider or hospital was PPO or non-PPO, if the patient was admitted to the hospital.

Organ Transplants

Allowable Expenses incurred for a Covered Transplant Procedure during an eligible Employee's or Dependent's Transplant Benefit Period will be payable, up to 100% of the contract rate, provided that:

A. The recipient must obtain prior approval from Anthem Blue Cross for certification of medical necessity and that the procedure is not considered experimental under the terms of the Plan;

B. The recipient does not suffer from a terminal illness and is reasonably expected to live at least one or more years beyond the transplant date;

C. The recipient has the transplant performed at a PPO facility (or Center of Excellence) approved by Anthem Blue Cross, and the physicians and surgeons are approved by Anthem Blue Cross; and

D. Coverage for the organ transplant and related expenses is limited to claims incurred up to 12 months after the date of transplant, for procedures approved and certified by Anthem Blue Cross as medically necessary.

The Plan covers charges approved by Anthem Blue Cross for human organ and tissue transplant services, including solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations:

> Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and cost for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are Medically Necessary, not Experimental, human to human or tissue transplants, including: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney*, kidney/pancreas*, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.
>
> ***The Plan requires participants to enroll in Medicare (Parts A and B) when a participant has End-Stage Renal Disease, including when the participant needs a kidney transplant.***
>
> Transplant services received at a *network hospital* or *Anthem Centers of Medical Excellence* are payable at up to 100% of the contract rate. An "Anthem Center of Medical Excellence" is a hospital which provides an exceptionally high concentration of expertise and related resources centered on all types of transplants or a specific type of transplant that is specifically contracted with Anthem.

Allowable Expenses are expenses expressly listed below that are directly related to a Covered Transplant Procedure. Benefits paid for Covered Transplant Procedures may not be more than the Allowable

Expenses listed below and, in any event, may not exceed the UCR charge determined by the Board of Trustees in its sole discretion.

The Fund will pay the following Allowable Expenses incurred as the result of a Covered Transplant Procedure during your or your Dependent's Transplant Benefit Period:

1. Hospital room and board and medical supplies.
2. Diagnosis, treatment and surgery by a Doctor.
3. Rental of wheelchairs, Hospital-type beds and other mechanical equipment when Medically Necessary.
4. Local ambulance service, medication, x-rays and other diagnostic services, laboratory tests and oxygen.
5. Rehabilitation therapy including: speech therapy (however, not for voice training or speech impediments), audio therapy, visual therapy, occupational therapy, and physiotherapy.
6. Surgical dressings and supplies.
7. If the Covered Transplant Procedure is not performed as scheduled due to the Recipient's medical condition or death, benefits will be limited to Allowable Expenses incurred in #1 and #2 above.
8. Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs include surgery necessary for organ removal, organ transportation and the transportation of the donor (refer to Transplant Travel Services below), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Cost related to the search for, and identification of a bone marrow or stem cell donor for allogeneic transplants are also covered.
9. *Transplant Travel Services* – Charges for certain non-taxable travel expenses incurred in connection with certain approved transplants, may be covered under the Plan subject to conditions and limitations. Transplant for travel benefits are not available for cornea transplants. Transplant Travel Services include transportation of the recipient and a companion to and from the transplant facility. If the recipient is a minor, the Transplant Travel Services include two persons traveling with the minor. Reimbursement for lodging and meals is limited to $200 per day. The Transplant Travel Services benefit paid for all transportation, lodging and meals related to a single transplant procedure will not exceed $5,000 (all inclusive).

No benefits will be payable by the Plan for the following:

a. Animal and/or mechanical organs except pumps and valves.
b. Any expense incurred for which the participant would not legally have to pay if there was no coverage for benefits.
c. Custodial care.

d. If an Employee or Dependent establishes a Benefit Transplant Period and subsequently loses coverage under the Plan, all benefit payments cease at the time coverage terminates.

e. Any organ or tissue transplant required as the result of an accidental injury or illness that is not covered by the Plan.

f. Unrelated donor search charges.

Other Frequently Utilized Medical Services

For your convenience, the following is a list of many other commonly prescribed medical services that are covered under the Medical Plan. This list is only a summary and may not reflect all limitations or exclusions.

- **Allergy Injections –** Covered when administered at a physician's office.
- **Ambulance** – Covered for services to and from the nearest facility equipped to provide the required treatment when the service is provided by a licensed professional ambulance and is land transportation, except where an emergency exists and the resulting injuries make use of an air ambulance medically necessary.
- **Chemotherapy**
- **Durable Medical Equipment (DME)** – The following are paid at 80% of UCR: rental (or purchase, if the cost is less than the rental for the period required) of durable medical equipment such as oxygen, anesthesia, a wheelchair, or hospital bed, for medically necessary therapeutic treatment of a covered illness or non-industrial injury, and which is:
    - of no further use when medical need ends; and
    - usable only by the patient; and
    - not primarily for the comfort or hygiene of the eligible individual, or solely to aid the caregiver; and
    - not for environmental control; and
    - not for exercise; and
    - manufactured specifically for medical use; and
    - approved as effective and usual and customary treatment of a condition as determined by the Plan; and
    - FDA approved; and
    - not for prevention uses; and
    - authorized by Anthem Blue Cross if the purchase price exceeds $2,000.
- **Hearing Aids** (including cochlear implants) – If required as a result of congenital defect, illness, or injury.
- **In-Vitro Fertilization** – Covered up to maximum listed on page 25 upon submission of medical records establishing participant or covered spouse or domestic partner's infertility.
- **Mammograms** – Routine mammograms paid at 100% – limited to one (1) baseline mammogram for women between ages thirty-five (35) and thirty-nine (39), once every two (2) calendar years for women between ages forty (40) and fifty (50), and once every calendar year after age fifty (50). Non-routine mammograms are covered if medically necessary.
- **Mastectomy** – Includes:
    - Reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedema.

- **Medical Supplies and Services**
  Except as noted below, the following items are paid at 80% of the contract rate (if PPO), or of Usual, Customary and Reasonable charges (if non-PPO) as defined by the Plan.
  - **Artificial limbs and artificial eyes**—external prosthetics covered for non-dental use, including their fitting, to replace any natural limbs and eyes you lose while covered under the Plan. Replacement of such devices will be covered only if required by a physical change, such as growth of a child, or as ordered by the attending doctor in connection with mastectomy.
  - **Blood—**charges for blood, blood plasma and non-replaced blood, including their administration.
  - **Immunizations**—are covered, unless the immunization is only required for you to travel outside the United States. This benefit will be paid at 100% if the immunization is a covered preventive service.
  - **Injectables**—Medically necessary antigens and other therapeutic drugs administered by injection by a physician.
  - **Medical supplies**—such as casts, splints, and dressings.
- **Osteoporosis Treatment** – Covered for all FDA-approved treatment, including bone mass measurement technologies, as deemed medically necessary by a doctor.
- **Physical or Occupational Therapy** – Covered when provided by a licensed or certified physical and/or occupational therapist.
- **Private Duty Nursing** – Covered when provided by a Registered Nurse ("R.N."), a Licensed Vocational Nurse ("L.V.N."), or Licensed Practical Nurse ("L.P.N.").
- **Prostate Specific Antigen ("PSA") Testing**
- **Radiation Therapy**
- **Second Surgical Opinion** – A "Second Surgical Opinion" means an evaluation by a second Doctor Board Certified in the medical specialization related to the proposed surgery covered by the Plan. The second surgeon's evaluation includes review of all tests and records on which the surgery was recommended and may include a physical exam and/or additional tests.
  - Limits applicable to Second Surgical Opinions: The following will not be covered:
    (1) Surgery or treatment rendered by the second surgeon;
    (2) More than two Second Surgical Opinions;
    (3) Second Surgical Opinions rendered without a physical examination.
- **Stop Smoking Benefits** – The Plan covers (without cost sharing or prior authorization) screening for tobacco use and up to two cessation attempts per year. A "tobacco cessation attempt" includes four counseling sessions of at least 10 minutes each and all FDA-approved tobacco cessation medications when prescribed. An office visit related to the use of nicotine patches is reimbursed in the same was as other doctor's visits for preventive care services.
- **Temporomandibular Joint ("TMJ") Dysfunction** – Treatment for TMJ or any other treatment of the face, neck or head for non-cosmetic purposes is covered if the procedure treats a condition caused by congenital deformity, injury or illness; charges for intraoral prosthetic devices are excluded.

Newborn's and Mother's Protection Act

Charges by a physician for newborn children while the mother is hospitalized following birth are covered up to 80% of the contract rate for a PPO provider, and up to 80% of UCR charges for a non-PPO provider. The Self-Funded Plan guarantees that:

a. the length of hospital stay for newborn children and their mothers following a vaginal delivery will be at least 48 hours.

b. the length of hospital stay for newborn children and their mothers following a cesarean section will be at least 96 hours.

Limitations: Generally, federal law does not prohibit the attending provider of a mother or newborn, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Furthermore, the Plan does not require that a provider obtain authorization from the Plan if he or she prescribes a length of stay of fewer than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Reconstructive breast surgery expenses incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered as shown below. Any exclusion of benefits for cosmetic surgery does not apply to this benefit. This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

1. Reconstruction of the breast on which the mastectomy has been performed.

2. Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts.

3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Colonoscopy or Sigmoidoscopy Examinations

The Plan will cover colonoscopy or sigmoidoscopy examinations as part of colorectal cancer screening received by participants and dependent spouses who are at least 50 years of age. Covered charges will be paid at 100% if services are performed by a PPO provider or 100% of Usual, Customary and Reasonable charges if services are performed by a non-PPO provider.

Colonoscopy and sigmoidoscopy examinations will be covered at intervals recommended by the U.S. Preventive Services Taskforce for your age and family history.

The Plan does not require prior authorization for diagnostic procedures; however, we urge you to be aware of the costs up front, because they can vary depending on where the test is performed. Generally, a colonoscopy can be performed in a surgery center or in a doctor's office. Preauthorization of the surgery center is not required for this procedure. If the test is performed by a PPO provider and qualifies as a preventive service, you will not have any out-of-pocket costs. If the test is performed by a non-PPO provider or in a non-PPO hospital, the costs can be much greater. Be certain that you and your physician know the extent of your coverage before you have the procedure performed.

Coverage of Treatment of Gender Dysphoria

Gender dysphoria is the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. The Plan covers medically necessary treatment for Plan participants and dependents who have been diagnosed with gender dysphoria, subject to utilization management review by Anthem Blue Cross. The following treatment is covered:

- Hormone therapy;

- Sex reassignment or gender affirmation surgery – where medically necessary and where gender dysphoria cannot be relieved through hormone therapy alone to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia) for covered individuals over the age of 18 who have lived for at least 12 continuous months in the gender role that is congruent with their gender identity;
- Psychotherapy – including assessment of gender dysphoria, assessment of options for gender identity and expression and possible medical/surgical intervention, and assessment of eligibility and referral for hormone therapy and/or surgery; and
- Coverage of puberty-suppressing medications where medically necessary for children and adolescents. Partially reversible and irreversible medical and surgical interventions for individuals under age 18 are subject to review on a case-by-case basis.

The Plan generally excludes cosmetic treatment. Therefore, coverage of surgical treatment for gender dysphoria does *not* include cosmetic services, including services used to improve the gender-specific appearance of an individual who has undergone or is planning to undergo sex reassignment or gender affirmation surgery. Cosmetic procedures include breast augmentation, electrolysis, facial bone reconstruction, facial implants, jaw reduction, liposuction, pectoral implants, voice modification surgery, and voice therapy.

What the Medical Plan Does *Not* Cover

Although the Plan covers most types of medical services and supplies, it does not cover everything a treating medical provider prescribes.

Claims for the following will not be covered by the Plan, nor will they count toward your annual deductible or out-of-pocket maximum:

1. Charges which are not eligible expenses. However, the Plan reserves the right to waive certain Plan benefit limitations to cover more cost-effective care that would otherwise not be considered an eligible expense.
2. Charges which are covered by Workers' Compensation laws or similar laws or which result from an employment-related accident or illness, except follow-up health examinations for an asbestosis-related illness. Charges for an illness for which the covered person is either entitled to benefits under any Worker's Compensation law or receives any settlement from a Worker's Compensation or occupational disease carrier. However, the Plan will cover such charges subject to your consent to a lien on any recovery on your Worker's Compensation claim.
3. Any medical treatment, hospital confinement or any portion of medical treatment or a hospital confinement that is not medically necessary.
4. Charges in excess of what the Plan determines to be Usual, Customary and Reasonable ("UCR").
5. Charges related to an injury or sickness for which you or your family member is not under the care of a doctor or provider.
6. Charges arising out of the pregnancy of a dependent child (other than charges related to the complications of pregnancy).
7. Hearing aids or eyeglasses. See Vision benefits on page 51.
8. Routine nursery care furnished for a newborn child beyond the first forty-eight (48) hours following

a normal vaginal delivery or the first ninety-six (96) hours following delivery by cesarean section.

9. Charges for any injury you receive while committing or attempting to commit a felony or any illegal activity, or as a result of such activity.
10. Services or supplies provided to you or a covered family member for a military service-connected disability which is covered under any governmental plan or law or provided by any non-military-connected hospital or institution which does not require you to pay for the expenses in the absence of insurance.
11. Services or supplies provided by a hospital or institution for active military personnel or a Veteran's Administration hospital, except if:
    a. you are a veteran receiving care for a non-military service-connected disability.
    b. you are a retired veteran or the family member of an active or retired veteran receiving inpatient hospital care for a non-military service connected disability.
12. Charges for injury or illness resulting from an injury suffered as a result of war or any act of war, whether declared or not, or armed aggression incurred during active duty or training in the National Guard or the reserves of any state or country.
13. Charges as a result of participation in a riot of civil disorder.
14. Charges that you would not legally have to pay (or would not be charged for) if you had no medical coverage. In addition, the Plan does not pay benefits when there are no out-of-pocket expenses other than deductibles by the covered person, such as services provided-through an HMO.
15. Charges for services or supplies paid for by any local, state (except Medi-Cal) or federal government agency, including Medicare (where Medicare is the appropriate primary payer).
16. Charges for hospital stays, services and supplies you receive before you are eligible for coverage under the Plan or after your coverage ends.
17. Charges for which a third party may be liable or legally responsible. Refer to page 77 for details.
18. Charges made by an individual who usually lives in the same household as the covered person, or who is a member of his or her immediate family, or the immediate family of his or her spouse.
19. Dental services and supplies, unless the expense is necessary for repair or alleviation of damage to natural teeth resulting from an accident. Refer to page 43 for other dental benefits.
20. Drug or alcohol addiction expenses, except detoxification. See page 54 for your drug and alcohol treatment benefits under the Recovery Program.
21. Pre-marital examinations.
22. Charges incurred in connection with treatment that is cosmetic, other than:
    a. Reconstructive surgery to restore tissue damaged by injury or illness, including surgery to one or both breasts to reestablish symmetry following a mastectomy; or
    b. Treatment of a child to correct a congenital disease or anomaly, including an oral defect.
23. Charges incurred for a treatment that is not generally accepted by the medical profession, or is listed as experimental, under investigation, or limited to research:
    a. By the federal Food and Drug Administration ("FDA"), the American Medical Association ("AMA"), Diagnostic and Therapeutic Technology Assessment ("DATTA") or the Office of Medical Application of Research of the National Institute of Health Office of Disease Prevention ("ODP"); or
    b. If a treatment has not been addressed by one of the organizations listed above, the Plan may determine if a treatment is appropriate based on the advice of its medical review department and/or an independent medical reviewer or other medical experts.
    c. The Plan covers participation in clinical trials subject to Preauthorization. If the Plan authorizes participation in a clinical trial the Plan will cover routine costs associated with this trial. This means that routine costs, services and supplies will be payable during the time the eligible individual is participating in the clinical trial and the Plan's standard benefits will

apply.

24. The determination, which will be made without regard to "medical necessity," will be subject to Plan appeal procedures. To determine whether a particular accommodation, service, supply, or other item meets the definition of "experimental treatment," the Trust may review established utilization review procedures and refer to current applicable literature, including AMA guidelines, and federal and state laws and regulations.
25. Services ordered by a court to be obtained by a Participant or dependent.
26. Investigative treatment (see "experimental treatment or procedures" above).
27. Eye Surgery or other procedures to correct refractive errors, such as Lasik surgery. Charges incurred for the purchase or fitting of eyeglasses or contact lenses. However, charges incurred for contact lenses or eyeglasses required immediately following and as a result of cataract surgery will be considered a covered medical expense. Note that such charges may be covered as Vision benefits. See page 51 for your vision care benefits.
28. Outpatient prescription drugs. See page 35 for your prescription drug benefits.
29. Drugs or medicines, except while confined to a hospital or that must be administered by a doctor in a clinical setting.
30. Reversal or attempted reversal of an elective sterilization procedure.
31. Elective abortions, except where the life of the mother is in danger if the procedure is not performed.
32. Treatment for paronychia (except infectious paronychia) and routine foot care. Excision of corns or calluses or any manipulative procedure on the foot, except for closed reductions of fractures or dislocations.
33. Examinations or check-ups not related to the symptoms of an illness or injury, except as otherwise provided as a preventive benefit.
34. Custodial care or rest cures.
35. Therapy, supplies or counseling for sexual dysfunction or inadequacies. Penile implants are covered subject to medical necessity.
36. Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.
37. Educational services, telephone consultations and transportation, except ambulance.
38. Food supplements or nutritional counseling except when prescribed to treat a specific medical condition (including a diagnosis of obesity) and provided by a licensed dietitian.
39. Rental or purchase of ramps, elevators, stair lifts, pools, spas, hot tubs and filtering systems, saunas and car hand controls.
40. Modifications made to your home, property or vehicles, regardless of their therapeutic or ease of access value.
41. Treatment, services or programs for weight reduction, diet control or obesity, including gastric bypass surgery. Also excluded are health club memberships, physical fitness programs, and nutritional counseling and food supplements, with the exception of educational/nutrition course of treatment for diagnosis of diabetes, other medically necessary nutritional counseling (see above), or screening and multicomponent behavioral interventions for obesity where part of medically-necessary preventive care.
42. Therapeutic devices or appliances, including support garments and other non-medical items or appliances, regardless of their intended use.
43. Immunizations required solely for travel outside the United States.
44. Expenses related to any false or fraudulent information provided to the Plan regarding the name of the patient or provider, the services or treatment provided, the amount of charges or any other information of material importance to the Plan's processing of the claim.

Prescription Drug Benefits

Who Is Covered Under the Plan

Participants enrolled in Kaiser HMO receive their prescription drug coverage through Kaiser. Your coverage is described in the Kaiser Explanation of Coverage.

Prescription drug benefits are provided by ElixirRx for all participants and covered dependents enrolled in the Self-Funded Medical option. The Plan pays benefits for drugs that have been prescribed as a result of an accidental injury, illness or pregnancy.

Prescription drug benefits are available through a pharmacy and through mail order.

Obtaining Your Retail Prescription Drugs

When your doctor writes a prescription, you may fill it at one of the Plan's participating pharmacies.

	BENEFITS FOR COVERED SERVICES **Retail Pharmacy** **Up to a 30-day Supply**	**BENEFITS FOR COVERED SERVICES** **Mail Order** **Up to a 90-day Supply**
Prescription Drugs-ElixirRx **Generic** **Brand**	No Deductible or Copay Brand Name and Generics Covered at 100%	No Deductible or Copay Brand Name and Generics Covered at 100%

Generic medications contain the same active ingredients (what makes the medication work) as brand-name medications, but they often cost less. Once the patent of a brand-name medication ends, the U.S. Food and Drug Administration can approve a generic version with the same active ingredients. These types of medications are known as generic medications. Sometimes the same company that makes a brand-name medication also makes the generic version.

Certain medications may require special approval from your plan to be covered. This is called "prior authorization." If your doctor prescribes one of these medications, you, your pharmacist or doctor can begin the review process by calling ElixirRx customer service. A customer service advocate will work with your doctor's office to get the information for a prior authorization review.

- **Using the Retail Pharmacy Program**

At the participating pharmacy, simply present your ElixirRx ID card to the pharmacist. The Plan pays for all lawfully prescribed, FDA-approved drugs not found under the heading on page 38, *"What the Prescription Drug Program Does Not Cover."*

Your Plan's retail pharmacy network includes many national chains and most independent pharmacies. There are two ways to quickly and easily find a retail pharmacy near you:

- Use the Locate a Pharmacy tool at elixirsolutions.com/
- Call a customer service advocate at 833-656-1506

- **Using the Mail Order Program**

To obtain drugs through the mail order program, contact Elixir Pharmacies for an order brochure and a patient profile form at (866) 909-5170 or www.Elixirpharmacies.com. Then, complete the required information and enclose it with your doctor's prescription in the postage-paid envelope or have your doctor send your prescription directly to Elixir Pharmacies.

Prescriptions are shipped free of charge anywhere in the United States via UPS or USPS standard delivery. Shipments will be sent to your home or another location of your choice. ElixirRx can deliver medications to P.O. Boxes as long as you have a physical address on file. Please allow enough time for delivery when you place your order so that you do not run out of medication. If you need rush delivery, your order can be shipped overnight for an additional charge.

- **Expenses Covered by the Plan**

Eligible prescription drug expenses covered by the Plan include charges for outpatient prescription drugs that are:

- Medically necessary,
- Prescribed by a licensed doctor,
- Can be obtained only with a prescription from a licensed doctor (except for diabetic and ostomy supplies),
- Amounts within ElixirRx's usual, customary, and reasonable limits, and
- Covered by the Plan.

Eligible expenses for a single prescription are limited to a 30-day supply at retail and a 90 day-supply from the Mail Order Program. Long-term and maintenance medications determined to be medically necessary by your doctor are also eligible expenses.

Specific expenses covered by the Plan include eligible charges for oral contraceptives; and insulin, diabetic supplies, and ostomy bags and devices. For more information on what specific medications are covered by the Plan, call ElixirRx at (833) 656-1506.

- **Coverage of Injectables and other "Specialty" Drugs**

"Injectables" are any drugs – other than injectable drugs routinely prescribed for diabetes or Epinephrine used for allergic reactions – that are to be administered by injection.

"Specialty" drugs are high cost pharmaceutical products with special administration, handling and/or clinical support requirements which may be taken orally, by injection or by other means and may be subject to special storage requirements. Specialty medications are typically prescribed for complex chronic conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C, hemophilia or pulmonary arterial hypertension, and for diseases more prevalent in the general population, such as cancer. If you have any questions concerning whether your medication is considered a specialty medication subject to these requirements, contact ElixirRx at (833) 656-1506.

If you are prescribed an Injectable or Specialty drug your doctor should call ElixirPharmacies toll-free at (877) 437-9012 to speak with an intake representative. ElixirPharmacies pharmacists will consult with your physician by telephone to explain the medication and its storage requirements, precautions, potential adverse effects, dosing parameters and instructions for use. ElixirPharmacies pharmacists may contact you throughout the duration of therapy to work with you and/or your doctor to foster proper use of the medication and encourage appropriate management of any possible side effects.

After consultation with your doctor ElixirPharmacies may suggest alternatives to the Specialty drug; however, the decision regarding whether to prescribe a Specialty or Injectable drug remains up to your doctor.

- **Coverage of Drugs Available Without a Prescription**

The following drugs, although available without a prescription, are covered only when prescribed in writing by a doctor:

- Diabetic supplies, including: insulin, insulin syringe, needles, sugar test tablets, sugar test tape, acetone test tablets, benedict's solution or equivalent when prescribed by a doctor;
- Anti-acids, including: aluminum hydroxide, with magnesium trisilicate, aluminum and magnesium hydroxide gel, calcium carbonate, magnesium carbonate suspension, and dihydroxy- aluminum aminoacetate;
- Colostomy apparatus;
- Eye and ear medications;
- Therapeutic vitamins;
- Elixir terpin hydrate, epinephrine, ephedrine sulfate, ferrous sulfate; and
- Non-prescription drugs required to be covered in compliance with the Affordable Care Act including, but not limited to, Aspirin, folic acid supplementation, fluoride supplementation, iron supplements, and Vitamin D.

- **Birth Control Pills**

The Plan covers Birth Control Pills, at no cost, at a participating pharmacy or through the mail order program.

- **What the Prescription Drug Program Does Not Cover**

Generally, a drug will be covered if it has been approved by the Food and Drug Administration ("FDA") and not otherwise excluded by the Plan. The following lists what is not covered under the prescription drug program:

- Prescription drug expenses that are not medically necessary, prescribed by a doctor, within the reasonable and customary limits, or are not covered by the Plan;
- Drugs that have not been prescribed in writing by a doctor (even if such drugs are available without a prescription);
- Immunization agents (however, preventive services are covered);
- Biological serums;
- Blood or blood plasma;
- Drugs prescribed as a result of war or acts of war;
- Drugs furnished or payable under any plan or law of any government agency or organization, Worker's Compensation law, or under any insurance plan or similar plan;
- Drugs that are not dispensed by a licensed pharmacist;
- Charges for vitamins, dietary supplements, or other drug or nutritional items that may be obtained without a prescription (except drugs or items covered as a preventive service, insulin, diabetic supplies, syringes, and ostomy bags and devices).
- Drugs or medicines that when taken in accordance with the doctor's direction will exceed

the 100-day period without the necessity of a refill; or any refill dispensed after one (1) year from the date of the original prescription;

- Charges for cosmetics or health and beauty aids;
- Charges for Prescription Drugs used primarily for cosmetic purposes;
- Drugs whose primary purpose is to promote or stimulate hair growth;
- Tretinoin in all dosage forms (e.g., Retin-A) for individuals twenty-six (26) years of age or older;
- Growth hormones;
- Compounded dermatological preparations, such as ointments and lotions;
- An unreasonable supply of drugs as determined by ElixirRx;
- Drugs prescribed for you for which any local, state (except Medi-Cal) or federal government agency, including Medicare, has paid;
- Expenses related to a military service-connected disability;
- Drugs provided by a hospital or institution for active military personnel or a Veteran's Administration hospital, except if you are a veteran receiving care for a non-military service-connected disability;
- Expenses that you would not legally have to pay (or would not be charged for) if you had no health care coverage;
- Drugs prescribed for an injury you receive while committing or attempting to commit a felony or any illegal activity, or as a result of such action;
- Non-federal legend drugs, unless specifically allowed under the Plan;
- Therapeutic devices or appliances, including hypodermic needles, syringes (except for those used for injectable insulin), syringes (except for those used for covered injectable drugs or vitamins), support garments and other non-medical items, regardless of their intended use;
- Any charge for the administration of a prescription drug (that are not otherwise covered by the Plan's coverage of Injectables or other Specialty Drugs);
- Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs, even if a charge is made to the covered person;
- Any drug dispensed during confinement in a hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which has on its premises a facility for dispensing pharmaceuticals;
- Infertility medications except to the extent covered under the Plan's Infertility Benefit described on page 25;
- Drugs or medicines prescribed for conditions or treatments not covered by the Plan's medical benefits;
- Investigational or experimental drugs or medicines unless all of the following conditions have been met:
    1. The drug is prescribed for the treatment of a life-threatening condition. "Life-threatening" means either or both of the following:
        - Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; and/or
        - Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

    2. The drug has been recognized for treatment of that condition by at least one of the following:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Dispensing Information (Volume 1 entitled "Drug Information for the Health Care Professional");
- Two articles from major peer review medical journals that present data supporting the proposed "off label" use or uses as generally safe and effective (unless there is clear and convincing contradictory evidence presented in a major peer reviewed journal).

- o Diet medications, appetite suppressants, dietary or nutritional supplements which can be purchased without a prescription;
- o Food and dietary supplements.

The ElixirRx Website

The ElixirRx website is the best source for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons. When you register at https://www.elixirrx.com/ and open an account, you can use the website's helpful tools and features to:

Look up the price of drugs covered by your plan
- Find lower-cost options
- Display or print your ID Card
- View your benefits in real time
- Review recent prescriptions
- Set or change your preferred pharmacy

Benefits for Retirees are described in a separate booklet. Medicare Retirees—If you are a Medicare-eligible retiree, you and your other Medicare-eligible family members do not need to enroll in Medicare Part D for prescription drug coverage as long as you are covered under the Health Care Plan. The prescription drug benefits you currently receive under the East Bay Drayage Drivers Security Fund are as good as or better than the standard Medicare Part D prescription drug coverage. Enrolling in Part D prescription drug coverage will increase your overall cost without giving you better benefits than the Plan provides and might actually jeopardize your coverage under this Plan and the Trust's Retiree Plan. As long as you have prescription drug coverage under the Plan, you are considered to have "creditable coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

Health Maintenance Organization (HMO) Option

The Trust offers medical coverage under one Health Maintenance Organization ("HMO") as alternatives to the Self- Funded Medical Plan. It is:

1. Kaiser Permanente HMO

If you choose a Kaiser, your and all of your covered dependents' prescription drug benefits will also be provided by Kaiser.

Your Kaiser HMO benefits are not described in detail in this booklet. For details on your Kaiser coverage, please refer to the *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between Kaiser and its members.

How Kaiser Works

Kaiser emphasizes preventive care, while also offering comprehensive medical coverage. If you enroll in Kaiser, you and your dependents must use Kaiser's doctors and facilities: other than in an Emergency which occurs outside the Kaiser service area, services provided by *non*-Kaiser doctors and facilities will not be covered (and whether an Emergency was present will be determined by Kaiser):

- Kaiser Permanente is a "staff model" HMO and may not require you to use a PCP; however, you must obtain all of your care at Kaiser's facilities.

Other features of Kaiser include:

- No annual deductibles; Kaiser covers most services (but Kaiser coverage is subject to different annual out-of-pocket maximums – see the chart on page 41); and
- No claim forms to file (in most instances).

Payment Provisions

Kaiser generally pays 100% of the cost of most covered services. Refer to your Kaiser plan booklet for additional details.

What Kaiser Covers

Many of the services covered under Kaiser have been summarized in the chart, found on the next page. This list is not intended to be exhaustive and any questions should be referred to Kaiser's *"Evidence of Coverage"* ("EOC") you receive as a Kaiser participant. Kaiser Plan EOC's are also available from the Administrator's Office.

What Kaiser Does Not Cover

See the Kaisers *"Evidence of Coverage"* for the list of applicable exclusions. However, it is important to remember that, except in emergencies that occur outside your Kaiser service area, you must receive all of your care through your HMO to be eligible for benefits.

If you have any questions about your HMO coverage, contact your HMO directly or refer to the HMO *"Evidence of Coverage"* booklet you receive as an HMO participant.

HMO BENEFITS CHART

HMO Services	Kaiser Permanente
Providers	Must use Kaiser providers
Annual Deductible	None
Annual Out-of-Pocket Maximum	One person: $1,500 Family (two or more persons): $3,000
Lifetime Maximum	None
Hospitalization	No Cost Share
Diagnostic X-Ray and Laboratory	No Cost Share
Doctor Office Visits	$5 per visit
Surgery	Outpatient: $5 per procedure Inpatient: No Cost Share
Pregnancy	Pre- and Post-natal Care: $5 per visit Inpatient care: No Cost Share
Home Health Care	No Cost Share
Skilled Nursing Facility	No Cost Share
Hospice Care	No Cost Share
Preventive Care	No Cost Share
Emergency Room	$5 per visit
Prescription Drug	Generic: $5 for 1 to 100 days Brand: $5 for 1 to 100 days
Mental Health	Outpatient: $5 per individual visit, $2 per group visit Inpatient: No Cost Share
Substance Abuse Through TAP *not* the HMO	See page 54 under the heading "*Substance Abuse Treatment*"

Other Benefits

Dental Benefits

The Trust Fund provides one dental option:

1. DeltaCare

This section describes how each dental option works and reviews the major benefit provisions of each plan.

DENTAL BENEFITS CHART

Dental Services	DeltaCare
Providers	Must use DeltaCare USA dentists
Annual Deductible	None
Annual Out-of-Pocket Maximum	None
Annual Maximum	None
Lifetime Maximum	None (except Orthodontia)
Percentage of Claims Covered	Paid in full (subject to the limitations and exclusions of the benefit schedule)
Orthodontia	Subject to $350 "start-up" fee; covers up to $1,800 in orthodontia services covered for adults and covered dependent children age 19 or older and up to $1,600 for dependents under age 19
Preventative Dentistry Teeth cleanings, fluoride application, annual exams	Cleanings once in a six-month period and dental exam once in a twelve-month period
Diagnostics Oral exams, X-rays	Full mouth X-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film Bitewing X-rays are limited to no more than one series of four films in any six-month period
Cosmetic Dentistry	Generally excluded; however, crowns, inlays, onlays and cast restorations are covered benefits on the same tooth only once every 5 years

Dental Services	DeltaCare
Endodontics Treatment of teeth, pulp and roots	Generally covered if required in accordance with professionally recognized standards of dental practice
Periodontics Treatment of the teeth, gums and jaw	Periodontal scaling and root planing are limited to four quadrants during any 12-month period Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered
Major Care Crowns, jackets, inlays, onlays and cast restorations	Crowns and jackets — No Cost Inlays and onlays (metallic) — No Cost Inlays and onlays (non-metallic) — Optional, Additional Fees apply Cast Restorations — No Cost
Prosthodontics Construction or repair of fixed bridges, partial dentures and complete dentures	Copay of up to $50.00 may apply The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is a benefit once every 5 years
Oral Surgery Extractions and other surgical procedures, including pre- and post-operative care	Generally covered if required in accordance with professionally recognized standards of dental practice
Sealants Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay	Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15 Benefits for sealants do not include the repair or replacement of a sealant on any tooth within 3 years of its application
For More Details	See DeltaCare Evidence of Coverage and Disclosure Form for complete details

The DeltaCare DHMO Program

How the DeltaCare Program Works

The DeltaCare option provides comprehensive dental coverage and is designed like a medical HMO, meaning that you must use a DeltaCare network dentist.

1. Choice of Provider

If you choose the DeltaCare Program, you and each covered family member must select and use a DeltaCare dentist. Each family member can choose a different dentist but they must be located at the same DeltaCare facility. You will automatically receive a listing of the DeltaCare dental offices in your area when you first become eligible for coverage and you may log on at www.deltadentalins.com for any updates to the listing.

2. Payment Provisions

Under the DeltaCare option, there is no annual deductible and benefits are paid at 100% for most preventive and diagnostic care services. A copayment may be required for routine care and major care.

What the DeltaCare Options Covers

Please refer to the "Dental Benefits Comparison Chart" on pages 43 to 45 and the DeltaCare *Evidence of Coverage,* ("EOC") which is available from Delta and from the Administrator's Office.

What the DeltaCare Program Does Not Cover

Please refer to the DeltaCare EOC for the Plan exclusions and limitations. Plan booklets are also available at the Administrator's Office.

Vision Benefits

Vision benefits are provided through Vision Service Plan ("VSP").

Through **Vision Service Plan** ("VSP)	
If you use a VSP Provider: ▪ No copayment ▪ Exams – once in any 12 months ▪ Frames – one pair in any 24 months – up to $195 and 20% off the amount over $195 ▪ Lenses – one pair in any 12 months – paid in full for (1) single vision, lined bifocal, and lined trifocal lenses; (2) blended, progressive, photo-chromics, tints and dyes; and (3) polycarbonate lenses for dependent children. Other lens treatments are not covered. ▪ Contacts in lieu of glasses – one pair in any 12 months – up to $105 per pair and payment for lens exam (fitting and evaluation) ▪ Replacement pair of glasses – subject to an allowance of up to $195 and a $10 copayment The covered amount is subject to a VSP allowance. Some frames and lenses will exceed this allowance and you will be responsible for the difference. The amount not covered for vision benefits does not apply to your Medical Plan Annual Out of Pocket Maximum.	**If you use a Non-VSP Provider:** ▪ No copayment ▪ Exams – Once in any 12 months – up to $50 ▪ Frames – Once every 24 months – up to $70 ▪ Lenses – Single vision – up to $50 per pair – Lined bifocal – up to $75 per pair – Trifocal – up to $100 per pair ▪ Contacts – up to $105

How the Vision Program Works

You may receive vision care services through VSP or non-VSP doctors but when you use a VSP doctor, you will generally receive greater benefits than you would if you use a non-VSP provider.

Finding a VSP Provider

To find a Vision Service Plan Optometrist call VSP at (800) 877-7195; or log onto the VSP website at www.vsp.com.

What the Vision Program Covers

- A comprehensive vision **exam** once every **twelve (12) months**,* including a refraction test to determine the need for glasses, binocularity analysis, and testing the overall health of the eyes and related optic structures.
- Additional testing for glaucoma and depth perception.
- Single vision, lined bifocal, lined trifocal or lenticular **lenses** once every **twelve (12) months**.*
- VSP fully covers eyeglass **frames** once every **twenty-four (24) months**.* If you select a frame that exceeds the allowed amount, you will be responsible for payment of the difference.
- **Contact lenses** and the contact lens exam (fitting and evaluation) are covered (in lieu of lenses and a frame) once every **twelve (12) months**,* regardless of whether you use a VSP doctor. If you obtain contact lenses, you will not be eligible for new frames for twenty (24) months.

- Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. $20 copay. Ask your VSP doctor for details.

(* The 12- or 24-month limitation dates from the last date of service.)

When You Visit a Non-VSP Provider

An eye exam or treatment or the purchase of lenses, frames or contact lenses from a provider who is not part of VSP's network, is covered but your out-of-pocket costs are likely to be higher.

When you use a non-VSP provider, you will be reimbursed according to the schedule above. If the scheduled benefit is not enough to cover the entire cost of the service, you pay the remaining charges. Note that the same frequency guidelines outlined under "What the Vision Program Covers" apply when you visit a non-VSP provider.

Replacement Glasses

If you or your dependents break or lose glasses that have been furnished by the Plan before the applicable twelve (12) or twenty-four (24) month limitation, you may obtain a second pair as a replacement. A $10 deductible and all other Plan limitations described above apply to this second pair.

VSP Member Discounts

VSP offers two standard discount programs:

- Additional pairs of prescription eyeglasses are available at a 20% discount from the doctor's usual and customary retail charges.
- A 15% discount on professional services is available from VSP doctors when contact lenses are purchased.

To take advantage of these discounts, simply return to the same VSP doctor who performed your last covered eye exam within twelve (12) months from the date of the exam.

How to Access Vision Care Services

There are no claim forms to file when you use a VSP doctor. However, if you receive vision services from a non-VSP provider you must submit an itemized statement to VSP along with your bill.

To receive vision benefits, follow these steps:

- To obtain a list of VSP doctors call VSP at (800) 877-7195 or visit the VSP website at www.vsp.com. If you already have a vision provider, check the listing (or call your provider) to see whether he or she is a VSP doctor.
- Make an appointment and tell the optometrist's office that you are covered under VSP through the East Bay Drayage Drivers Security Fund. The VSP doctor will call VSP to verify your (or your dependent's) eligibility and plan coverage. If you are ineligible – for example, if you have already had an exam within the allotted time frame – the doctor's office will contact you to explain why, and to discuss your options.

When you visit a:

- **VSP doctor**, the doctor will perform an exam and itemize any non-covered charges that are your responsibility. The remainder of the charges will be paid by VSP.
- **Non-VSP provider**, you must pay the bill in full. Then within **six (6) months** of the date you received service you must mail an itemized receipt, together with the following information, to VSP:
    - Your name, address and Social Security Number
    - The patient's name and relationship to you (if other than you)
    - The patient's date of birth

  Send this information to: VSP, P.O. Box 997100 Sacramento, CA 95899-7100

If the scheduled amount is not enough to cover the full cost of services, you are responsible for the remaining charges.

What the Vision Program Does Not Cover

If you select any of the following, you will pay additional charges for:

- Blended lenses
- Contact lenses (except as previously described)
- Multifocal plastic lenses
- Oversize lenses
- Progressive multifocal lenses
- Coated or laminated lenses
- Frames that cost more than the Plan allowance
- Low vision care
- Lenses and frames which are lost or broken, except as permitted under "Replacement Glasses" on page 52

In addition, the Vision Program does **not cover** the following professional services or materials:

- Orthoptics or vision training and any associated supplemental testing
- Plano (non-prescription) lenses
- Two pair of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment

Substance Abuse Treatment Benefits

Treatment for alcoholism and chemical dependency for **all Plan participants and dependents – including Kaiser enrollees** – is provided under the Plan primarily through the Teamsters' Assistance Program ("TAP"). To reach TAP call (510) 562-3600.

What is the TAP?

TAP is a consultation and referral program established to provide assessment and referral counseling for chemical or alcohol abuse.

Benefits payable for coverage for any substance abuse expenses you may incur, may be reduced if not authorized by TAP.

How do I get assistance through TAP?

If you are in the San Francisco Bay Area, contact TAP by calling (510) 562-3600. If you are outside the San Francisco Bay Area, call 1(800) 253-TEAM. The TAP counselor will either schedule an appointment for a session with the counselor or direct you to the most appropriate health care professional or community resource for additional assistance or treatment.

If you are referred to a health care professional or community resource, the TAP counselor will monitor the services you receive to ensure that you are getting the help you need.

After you have completed a treatment or rehabilitation program, TAP provides "aftercare" support services including group meetings, fellowship activities, volunteer support, and special education classes.

What Is Covered Under The Plan?

It is strongly encouraged – but not required -- that you contact TAP before treatment for drug or alcohol use. If your treatment is not approved by TAP the benefits paid by the Plan may be reduced on grounds of medical necessity. Emergency inpatient admissions for substance abuse are subject to the same terms of admission as described for medical emergency inpatient admissions described on page 15. For Emergency admissions, you or your Physician must contact Anthem Blue Cross by the first working day following your admission to ensure that continued hospitalization is necessary.

The appropriate treatment will depend on your specific circumstances and may consist of hospitalization, outpatient care, and group or individual counseling. A "course of treatment" for purposes of coverage under the Plan begins on the day you are admitted for Emergency inpatient treatment or first meet with a TAP counselor or a health care professional concerning drug or alcohol use and ends on the earlier of, the date of your discharge by the facility or program or the date you end treatment without certification from TAP that you have completed treatment.

The "percentage payable" for substance abuse treatment at TAP network facilities will be the same as the percentage payable for Anthem Blue Cross network facilities. The percentage payable for treatment at out-of-network facilities will be the same as the "non-PPO" rate payable under the Medical Plan.

The Plan covers substance abuse treatment only from providers certified by The Joint Commission (formerly "JCAHO"). To determine whether your provider is Joint Commission-certified, call TAP or ask your provider for its Joint Commission certification.

TAP Benefits Chart	
Applies to ALL Plan participants, including Kaiser enrollees.	100% coverage in a Teamsters' Assistance Program (PPO) approved facility or 80% of UCR in a Non-PPO facility

Sleep Apnea Coverage

Obstructive sleep apnea is a common sleep abnormality where breathing during sleep is paused by the narrowing of the upper airway. This causes a lack of air to enter the lungs and less oxygen reaching vital organs. When your upper airway collapses or narrows during sleep, the body tries to compensate to overcome the perceived obstruction by making greater efforts to breathe air through the narrower airway, which often causes snoring.

Sleep Apnea specialists, SleepWorks, tests for and treats sleep apnea. If you test positive for sleep apnea, SleepWorks will provide and train you in the proper use of a PAP device to treat your Sleep Apnea. If you agree to be treated with the PAP device, you will be expected to adhere to the SleepWorks therapy. "Adherence to therapy" means using your PAP device in excess of four hours per night for at least 21 nights each month for at least 10 months. Dependents are not eligible for this benefit.

If you agree to use a PAP device to treat your Sleep Apnea, then decide to drop out of the program (for any reason other than a medical reason that prevents you from using the device), SleepWorks will report discontinuance to the Fund and you will be charged for the balance of the Fund's fee to SleepWorks for your enrollment in treatment.

If you think you may have Sleep Apnea, call SleepWorks at 844-500-0960 to be tested by SleepWorks.

Life Insurance Benefits, Accidental Death and Dismemberment Benefits, and Disability Benefits

The Plan provides for the following types of insurance coverage through an insurance contract with the Union Labor Life Insurance Company ("ULLICO"):

- Employee Life Insurance
- Dependent Life Insurance
- Accidental Death & Dismemberment ("AD&D") Insurance
- Weekly Disability Benefits

None of these types of insurance coverage can be continued under the COBRA self-pay provisions of the Plan described on page 68.

Employee Life Insurance

The Employee Life Insurance benefit of **$25,000** is designed to pay a benefit to your beneficiary if you die while you are covered by the Plan.

- **Payment of Life Insurance Benefits**

Your beneficiary will receive payment after the insurance company approves the death claim. Payments are usually made in a lump sum but your beneficiary may choose to have all or a portion of the proceeds of your benefits paid in monthly installments. The amounts and terms of these installments will be determined at the time the election is made.

Generally, the benefits paid to your beneficiary will not be taxable. Proof of loss must be provided within ninety (90) days of the death or as soon as reasonably possible.

See the claims and appeals procedures, refer to *"Your Legal Rights and Administrative Information about the Plan"* section on page 92.

- **Naming Your Life Insurance Beneficiary**

You name your beneficiary by filling out the form provided by the Administrative Office. If you are married and want to designate a beneficiary other than your spouse, you must first obtain your spouse's written consent. To change your beneficiary, you must submit your request in writing on the form supplied by the Administrative Office. The change request takes effect the day it is received by ULLICO. If you name more than one beneficiary, you must specify the percentage of the benefit you want paid to each person. If you do not, the beneficiaries will share the benefit equally.

If there is no surviving beneficiary or you fail to elect a beneficiary, death benefits will be paid to the first surviving family member, in the order listed below:

- Your spouse;
- Your children (including legally adopted children);
- Your parents;
- Your brothers and sisters;

- The executor or administrator of your estate.

- **Employee Life Insurance While You Are Totally Disabled**

If you become "totally disabled" before age sixty (60), your Life Insurance coverage will continue without payment of premium for as long as you provide yearly proof of total disability or until you reach the age of sixty (60).

For the purposes of this feature, you will be considered "totally disabled" when, due to illness or injury, you are prevented from working in any job for wage or profit, for which you are qualified due to your education, training or experience. For purposes of the life insurance benefit, whether you are disabled is determined by the Life Insurance carrier.

You must apply for extended coverage and provide proof of disability within one (1) year of your last day of work as an active employee. This proof must establish that your total disability has continued for at least nine (9) months from the date you were last actively at work. Once you have been approved for this waiver of premium and continuation of coverage, it will remain in effect for as long as your total disability continues (or until retirement). However, to remain eligible, you must submit satisfactory written proof of continuing total disability once annually.

If you die within one (1) year of your total disability without submitting proof of your disability, and premium payments have been paid until the date of death, benefits will still be paid to your beneficiary upon notice of your death.

Please note that ULLICO reserves the right to have you examined (at its own expense) by a doctor of its choice at any reasonable time during the course of your total disability. However, it will not require such an examination more than once a year.

- **Dependent Life Insurance**

The Dependent Life Insurance benefit is designed to pay a benefit to you or another beneficiary if a dependent dies while you are covered by the Plan. Dependent Life Insurance is **not** a covered benefit for domestic partners and/or their children. Unless you elect otherwise, you (the covered Employee) are automatically the beneficiary for the dependent life insurance benefit.

Coverage Amounts

The Dependent Life Insurance coverage amount for your spouse is **$12,500**.

The Dependent Life Insurance coverage amount for your children is:

- Children age 6 months to age 20 – $1,000
- Children less than age 6 months – $100

Payment of Benefits

Payments made after the insured person's death are made in a lump sum, unless you elect to have the proceeds paid in installments under an optional plan that is then being offered by ULLICO. Generally, these benefits paid are not taxable. In order for the beneficiary to receive payment, the insurance company must approve the death claim. Union Labor Life requires proof of loss within ninety (90) days of the death or as soon as reasonably possible.

Dependent life insurance benefits will be paid to the first person or persons listed below:

- You (as the covered employee);
- Your spouse;
- Your children (including legally adopted children);
- Your estate.

Two or more persons entitled to benefits will be paid in equal shares.

Employee Accidental Death & Dismemberment ("AD&D") Insurance

The Employee AD&D Insurance benefit is designed to pay a benefit to your beneficiary if you die or suffer a dismembering injury due to a covered accident while eligible for the Plan.

If You…	The AD&D Insurance Plan Pays…
Die Lose both hands or both feet Lose sight in both eyes Lose one hand and one foot Lose either one foot or one hand and sight in one eye	$25,000
Lose one hand or one foot Lose sight in one eye	$12,250
No more than $25,000 will be paid for all losses resulting from a single covered accident.	

- **Payment of Benefits**

If you die or lose a limb or sight within ninety (90) days after (and as a result of) a covered accident, upon proof of loss, you or your beneficiary will receive a benefit based on the extent of loss as indicated in the table below.

No benefits are payable due to sickness or accidents that are a result of an injury, which arises out of or in the course of any employment with any employer.

- A "covered loss" means death or permanent loss of:
    - A hand, by the complete severance at or above the wrist joint
    - A foot, by the complete severance at or above the ankle joint
    - An eye, involving irrecoverable and complete loss of sight in the eye

- **AD&D Insurance Exclusions**

The AD&D Insurance does not cover any loss that is caused directly or indirectly by:

- Bodily or mental illness or disease of any kind

- Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound)

- Suicide or attempted suicide while sane or insane

- Intentional self-inflicted injury
- Participation in, or the result of participation in, the commission of an assault, felony, riot, or a civil commotion (except for an assault or felony determined to have been committed as an act of defense by the victim of domestic violence)
- War or act of war, declared or undeclared, or any act related to war, or insurrection
- Service in the armed forces of any country while such country is engaged in war
- Police duty as a member of any military, naval or air organization
- Travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the policyholder, a participating employer or the armed forces, or being operated for any training or instructional purpose

Weekly Disability Benefits

If you become "totally disabled" due to an accidental injury or sickness and are unable to work, the Plan provides a benefit of $40 per week for up to twenty-six (26) weeks.

You will be considered "totally disabled" as a result of bodily injury or sickness if your injury or sickness prevents you from engaging in any occupation for which you are qualified by reason of education, training or experience.

- Your weekly disability benefits will begin:
- Immediately after an accidental injury that results in total disability
- After seven (7) days for a condition which results in total disability, but was not caused by an accidental injury
- After four (4) days for a condition covered under Worker's Compensation which results in total disability, but was not caused by an accidental injury

If your disability (other than due to accidental injury) continues for more than twenty-one (21) days, you will receive a weekly disability benefit for the first week of your disability, which was not initially covered.

For weekly disability benefits to be paid, you must be under the direct care of a doctor. No benefits will be paid for disability due to intentionally self- inflicted injury.

If you have more than one (1) disability due to either (1) unrelated causes and separated by your return to work, or (2) related causes, but you have returned to work on a full-time basis for at least two (2) weeks in a row, then each disability will be considered a separate period of disability for determining your maximum benefit.

Disabilities, which do not meet the two conditions above, will be treated as one (1) period of disability and are subject to the maximum period of twenty-six (26) weeks.

Filing Claims for Disability, Life Insurance and AD&D Insurance

- **Filing an Initial Claim**

To submit your claim, call the Administration Office at (855) 263-7242 to request a claim form and return it to the Administrative Office. The Claims Administrator will issue a decision within ninety (90) days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within one hundred eighty (180) days. Written notice of the extension will be provided to you before the end of the initial 90-day period and will state the reason(s) for the extension and the date you can expect a decision.

- **Appealing a Denied Claim for Disability, Life Insurance and AD&D Insurance**

You (or your authorized representative) may appeal a denial of the claim. The written appeal must be submitted within sixty (60) days after notice of the denial of the claim to the following address:

Corcoran Administrators
P.O. Box 5030
Walnut Creek, CA 94596

The Administration Office will notify you of the final decision within sixty (60) days after receiving the request for review, unless the Claims Administrator requires an extension and notifies you of that extension before the end of the initial 60-day period, in which case the final decision will be made within one hundred twenty (120) days. The notice of extension will state the reason for the extension and when you can expect a decision.

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: If you are enrolled in the Anthem HMO, 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 HMO, you must live or work within 30 miles of an HMO hospital and doctor. If you are enrolled in the Anthem or Kaiser HMO and move to an area outside of the service area, you can change your medical option outside of Open Enrollment.

In the first year of your eligibility, your only option for Medical coverage is under Kaiser. You may change your plan options during the first open enrollment period after you first become eligible for coverage.

When Coverage Ends

Generally, coverage under the Plan ends when you or your family members no longer meet the requirements for Plan coverage. However, there may be times when continued coverage is available for a limited period of time. (See pages 68-73)

Coverage for you and your family members will generally end on the earliest of the following dates:

- The end of the month for which the last employer contribution is made on your behalf;
- The date your employer terminates participation in the Plan;
- 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;
- The date you or your family member enters full-time military service. Special provisions apply to you if you are a military reservist called to active duty. See page 65 for details;
- The date you die. However, your surviving family members may continue coverage with certain limitations, as described on page 68-73;
- The date you no longer satisfy the Plan's eligibility requirements;
- The date your COBRA continuation coverage ends, as described on pages 68-73; or
- The date the Plan is terminated.
- 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:

1. 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;
2. 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:

1. The date your Dependent ceases to be eligible as a Dependent under the Plan;
2. The date your coverage terminates;
3. The date your Dependent enters into the military on an active duty, full-time basis;

4. The date the Plan terminates, or terminates coverage for Dependents; or

5. The date indicated on a Qualified Medical Child Support Order which has been accepted by the Plan.

Continuing Plan Coverage

When certain events occur in your life, protection under the Plan for you and your eligible family members can continue for a limited period of time. These life events are:

A. Disability (page 65)
B. Call To Active Military Duty (page 65)
C. Labor Dispute (page 66)
D. Retirement (page 66)
E. HMO Continuation Coverage (page 68)
F. Self-Payment (page 68)
G. COBRA Continuation Coverage (page 68)
H. Marketplace Coverage (Covered California) (page 73)
I. Life Insurance Coverage (page 73)

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.

Disability

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.

If you are totally disabled at the time your eligibility ends, *your medical benefits related to your* disability will continue during your disability until the earliest of the following:

- The date your total disability ends;
- The date that you become eligible for other group coverage without limitation as to your disabling condition; or
- The end of the twelve (12) month period following the end of your employer paid coverage.

This twelve (12) month extension applies to you only and not to your eligible Dependents.

Call to Active Military Duty

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 months, for a total of twenty-four (24) months of continuation coverage. This extended coverage runs concurrently with any continuation coverage rights under COBRA.

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.

Note: (1) This extension of coverage does not apply to weekly disability benefits during the dispute; and (2) The Plan's self-pay period does **not** run concurrently with your COBRA period so you may be entitled to the full COBRA period after the Labor Dispute extension has run.

Retirement

Benefits for Retirees are described in a separate Retiree Plan booklet.

Only retirees and their dependents who meet the eligibility rules described below are eligible for coverage.

General Requirements:

- You must not be eligible as an active or retired employee under any other group health policy or any health care or service plan;

- You must be receiving pension benefits from the Western Conference of Teamsters Pension Fund or meet the eligibility requirements for such benefits by reason of age and length and continuity of employment if you are not enrolled in that Plan;

- You must satisfy the Service Requirements described below;

- You must complete the written application form required by the Trust and submit it to the Administration Office upon receipt of your Pension Award Certificate. Late applications will be accepted only upon approval of the Trustees for good cause; and

- You must make the required contribution as set forth by the Board of Trustees.

- If you meet the Retiree Plan's eligibility requirements, you may delay enrollment in the Retiree Plan for you and (if you are married or have a Domestic Partner) your Spouse/Domestic Partner if as of your retirement date you were covered under another group medical plan (such as your Spouse's employer's plan) or a comprehensive individual plan (such as one purchased on Covered California) and when you enroll in the Retiree Plan you can provide satisfactory proof of continuous, uninterrupted coverage under another group health plan since the date of your coverage in the Active Plan ended.

Medicare Requirements:

If you and/or your eligible dependents are eligible for Medicare, you and/or your eligible dependents must be enrolled in Medicare Parts A and B to participate in the retiree plan. If your spouse is employed

and eligible for Medicare, your spouse must enroll in Medicare Parts A and B to participate in the retiree plan.

Service Requirements:

- Retirees with fewer than 5 years of coverage in an East Bay Drayage Drivers plan for Active employees are not eligible to participate in the Retiree Plan.

- You must have been covered under as an active employee by the East Bay Drayage Drivers Security Fund for at least 60 of the 84 months immediately preceding your retirement date* including at least 12 months of the 24 months immediately preceding your retirement date* and had at least 5 years of coverage under the East Bay Drayage Drivers plan for Active employees.

If you do not meet the specific qualifications described above, you still meet the service requirement if:

- You have been covered as an active employee by the East Bay Drayage Drivers Security Fund for a total 180 months or more within the 240 months immediately prior to your retirement date* including at least 12 months of the 24 months immediately preceding your retirement date.*

OR

- You have been covered as an active employee by the East Bay Drayage Drivers Security Fund for at least 300 months, including at least 12 months of the 24 months immediately preceding your retirement date.*

* Your "retirement date" is the date of your retirement as determined by the Western Conference of Teamsters Pension Plan. Please review your Retiree Application or contact the Administration Office for the most current schedule of Retiree Plan co-payment rates.

If you meet the Retiree Plan's eligibility requirements, you may delay enrollment in the Retiree Plan for you and (if you are married or have a Domestic Partner) your Spouse/Domestic Partner if, as of your retirement date, you were covered under another group medical plan (such as your Spouse's employer's plan) or a comprehensive individual plan (such as one purchased on Covered California) and, when you enroll in the Retiree Plan, you can provide satisfactory proof of continuous, uninterrupted coverage under another group health plan since the date your coverage in the Active Plan ended.

Retiree Self-Payment:

Continuation of eligibility from month to month requires a self-payment. The amount of these self-payments will be determined by the Trustees in accordance with their evaluation of the needs of the Plan. Self-payments for you and your dependents are due on the first day of the month. No claims will be paid for claims incurred in a month for which self-payment has not been submitted. Your first payment will be due effective as of your first month of coverage in the Retiree Plan.

- Your monthly payments will be due on the 1st of each month and will become delinquent on the 10th day of the month. Accounts delinquent 90 days or more will be terminated.

HMO Continuation Coverage

Under California law, HMOs such as Kaiser and Anthem Blue Cross are required to offer to continue benefits for certain individuals beyond the period of federal COBRA. You and/or your dependents may be eligible for such coverage if you pay the full cost of the continuation coverage and if certain conditions are met. For details on your benefit coverage, please refer to Kaiser Foundation Health Plan or Anthem Blue Cross *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between Kaiser Health Plan or Anthem Blue Cross and their members.

Please note that dental, vision, substance abuse, and prescription drug coverage are subject to COBRA continuation coverage but cannot be converted to an individual policy.

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, 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 Continuation Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that requires the Trust Fund to provide you and your eligible Dependents (called "Qualified Beneficiaries") with the opportunity to continue your health coverage at your expense when your employer-paid health coverage ends. Qualified beneficiaries include you and your eligible dependents who are covered under the Plan at the time your coverage would end for one of the reasons described below. Qualified beneficiaries also include children who are born to or adopted by you while you are covered by self-payment under COBRA. Individuals who decline COBRA when first eligible are not qualified beneficiaries. COBRA applies to medical, dental, vision, and substance abuse treatment 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 "Life Insurance Coverage" on page 73).

Qualifying Events

You and your covered family members may elect to continue Plan coverage under COBRA for up to 18 months if your coverage ends because:

1. your employment terminates (except if you are terminated for gross misconduct), or

2. 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).

Dependent Qualifying Events

Plan coverage may be continued for a covered family member (please note that your domestic partner and his/her eligible dependents are not eligible for COBRA) for up to 36 months if his or her coverage ends due to one of the following events:

1. your death,

2. your divorce (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,

3. your child no longer qualifies for coverage under the terms of the Plan (he or she turns age 26), or

4. your entitlement to Medicare benefits.

It is the responsibility of a covered employee or qualified beneficiary to inform the Trust Fund Office of the occurrence of certain qualifying events within 60 days. If the qualifying event is a divorce, or a child's loss of eligibility (refer to page 3 for dependent eligibility), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs or the date on which coverage would end because of the qualifying event, whichever is later.

If, when you terminate employment or your hours are reduced, you are entitled to Medicare benefits, you will not be eligible for COBRA coverage. However, your covered family members may elect COBRA coverage for up to 36 months from the date you became entitled to Medicare, or up to 18 months from the date you terminated or your hours were reduced, whichever is longer.

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.

Extended Coverage Due to a Disability

You or your covered family members may extend COBRA coverage from 18 to 29 months if, when you terminate employment or your hours are reduced, or within 60 days thereafter, you or your family member is or becomes disabled as determined by Social Security. If you or your family member elects the extension, you will pay 150% of the full group premiums for the additional 11 months of coverage. You must notify the Trust Fund Office that you want the extended COBRA coverage within 60 days of

the date you or your dependent is declared disabled by Social Security, but not later than 18 months from the date you or your dependent initially became eligible for COBRA coverage.

Extended COBRA coverage will end if you are no longer disabled. You or your dependent must notify the Trust Fund Office within 30 days of the date you are determined by Social Security to be no longer disabled.

When any of these events occurs, the Trust Fund Office will give you an election form and more information about the cost of coverage and payment method. You or your family member must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later.

Extended Coverage Due to a Second Qualifying Event

If your covered family member elects COBRA coverage due to your termination of employment or reduction in hours, he or she will be entitled to additional coverage – up to a total of 36 months – if there is a second qualifying event during the first 18 months, such as:

1. you die,
2. you divorce,
3. your child no longer qualifies for coverage under the terms of the Plan, or
4. you become entitled to Medicare benefits.

If such a second qualifying event occurs while you or your covered family members are receiving COBRA continuation benefits, you (they) must notify the Plan in writing within 60 days of the occurrence of the second qualifying event or the date on which coverage would end because of the qualifying event, whichever is later.

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 (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

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.

Your written notice of a qualifying event must include the date of the qualifying event, i.e., the effective date of a divorce, the date on which a dependent child turned 26, or the date on which the Social Security Administration determined you to be disabled. (A copy of the notice of determination of disability by

the Social Security Administration must also be included.) You may use the notification form provided to you with your initial notice of COBRA rights, or simply provide written notice in any other form so long as it includes the foregoing information. Your notice to the Plan must be mailed by first-class mail within 60 days of the qualifying event to: East Bay Drayage Drivers Security Fund, c/o Corcoran Administrators, P.O. Box 5030, Walnut Creek, CA 94596.

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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:

1. "Core coverage" includes medical coverage (in the Trust Fund's Medical Plan or an HMO), prescription drug coverage, and substance abuse treatment.

2. "Core plus non-core coverage" includes the coverage listed above, plus vision and dental coverage.

3. Whether you choose "core plus" or "core" benefits only, the Plan's COBRA premium is a "composite" – 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.

Your benefits while you are covered under COBRA coverage will be the same as the coverage for active employees. Therefore, if there are any changes to the Plan for active employees, your benefits will also change.

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 for months 19 to 29.

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.

Election of COBRA Coverage

After receiving notice of a qualifying event the Plan Administrator will send you an election form, notifying you of your COBRA rights and giving you the opportunity to elect to take COBRA. You must return the election form within 60 days, and you must send your premium (representing 102 % of the cost of your benefits) for your initial month(s) of COBRA coverage within 45 days of returning the election form. (Premiums are 150% of cost for a qualified beneficiary on a disability extension.) Thereafter, your premium *must* be postmarked no later than the last day of the month for each month for which you want coverage. ***You will not receive any notice of premium due or monthly bill from the Plan,***

***and if you are late paying any premium your COBRA benefits will be stopped and you will be unable to renew them**.*

Your COBRA coverage will terminate if you do not make your premium payment before the end of the grace period.

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.

Your COBRA election form and all premium payments should be mailed to: East Bay Drayage Drivers Security Fund, c/o Corcoran Administrators, P.O. Box 5030, Walnut Creek, CA 94596.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or coveredca.com.

When COBRA Coverage Ends

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

1. The end of the 18-, 29- or 36-month COBRA coverage period;
2. The date your monthly COBRA self-payment is delinquent in excess of thirty (30) days;
3. The date your employer terminates its participation in the Plan and its active employees are enrolled in another group health plan;
4. The date you or your Dependent becomes covered by another group health plan;
5. The date a person on COBRA coverage becomes entitled to Medicare;
6. The month that begins thirty (30) days after a disabled person on extended COBRA coverage is no longer disabled; or
7. The date the Plan ends.

If you have questions concerning your Plan or your COBRA continuation coverage rights they should be addressed to the Trust Fund Office, at the address above, or to the contacts identified below. 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, contact the nearest Regional or District Office (see below) of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Employee Benefits Security Administration (EBSA)
Regional Office
71 Stevenson Street, Suite 915
San Francisco, CA 94105
Telephone: (415) 975-4600

Employee Benefits Security Administration (EBSA)
District Office
1111 Third Avenue, Suite 860
Seattle, WA 98101
Telephone: (206) 553-4244

It is important to keep the Plan informed of address changes. **To protect your family's rights, you should keep the Trust Fund Office 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 Trust Fund Office.**

Marketplace Coverage (Covered California)

There may be other coverage options for you and your family. You may wish to purchase coverage from the Health Insurance Marketplace ("Covered California"). In the Marketplace, you could be eligible for tax credits that lower 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 COBRA or a self-pay option does not limit your eligibility for coverage for a tax credit through the Marketplace. However, you should be aware that if you elect COBRA or a self-pay option upon losing your regular coverage, you will be ineligible for Marketplace coverage until the earlier of (1) the date you exhaust your COBRA or self-pay eligibility or (2) the next annual Marketplace open enrollment (October-December) unless you are entitled to special enrollment (e.g., you are adding a dependent).

You can find out more about your Marketplace options at the Covered California website: www.coveredca.com.

Life Insurance Coverage

If your Life Insurance coverage ends or is reduced for any reason, other than due to your age or retirement, or if the Trust Fund no longer offers the group policy, you may convert your Life Insurance from group coverage to an individual policy. Evidence of insurability is not required.

The individual coverage may not be a term insurance policy and it may not be for an amount greater than the benefit under the group coverage. You must pay your own insurance premiums if you convert your policy to individual coverage.

To convert to an individual policy, you must apply in writing to the insurance company within thirty-one (31) days from the date your insurance coverage stops. If you are eligible for conversion and do not receive notice at least fifteen (15) days before your 31-day grace period expires, you will have an additional fifteen (15) days from the day you receive the notice. The extension will not exceed ninety (90) days.

If the group coverage is amended so that it will no longer cover you, you may have the option to convert if the insurance policy had been in effect for five (5) years or more.

If you die during the 31-day period following your last day of work for the Company, benefits will still be paid as though you were covered.

If your Dependent's Life Insurance terminates for any reason, he or she will be entitled to convert their coverage on the same basis as you.

Coordination of Benefits

When you or your family members (or an organ transplant donor on your behalf) are eligible for benefits under this Plan as well as another health plan, the two plans are blended to ensure that the combined benefits are not more than the plans were intended to pay. This provision is called "Coordination of Benefits."

Here are some examples of other plans you or your family members may be covered under:

1. Other group insurance plans or health maintenance organizations, such as when you are covered as a dependent under your spouse's employer provided plan.

2. Other labor-management plans, union welfare plans, employer organization plans, or employee benefit organization plans.

3. Governmental programs or programs required or provided by any law.

If you or your family members are covered under more than one group plan, one plan is "primary" and the others are "secondary." The primary plan pays benefits before the secondary plans pay. If one plan has no non-duplication or coordination of benefits provision, it is automatically primary.

When the East Bay Drayage Drivers Security Fund is primary, it will pay the benefits described in this booklet. When the East Bay Drayage Drivers Security Fund is secondary, it will pay an amount to bring the total paid by the other plan and this Plan up to this Plan's "allowable expense." Provided, however, that the East Bay Drayage Driver Security Fund will pay no more than it would have paid as a secondary plan, had the primary plan paid under its provisions that would apply when it is the only plan involved.

An allowable expense includes any medically necessary, reasonable and customary item or medical expense incurred, a portion of which is covered under either this Plan or one or more other plans covering the person for whom the claim is made. Any item specifically excluded from coverage under this Plan can never be an allowable expense for purposes of coordination of benefits.

Allowable expenses cannot exceed the lesser of the following:

1. the normal charge billed for the expense by the provider,

2. the contractual rate for such expense under a preferred provider contract between the provider and this Plan,

3. the contractual rate under a preferred provider contract between the provider and the plan with which this Plan is coordinating benefits,

4. the scheduled amount for eligible expenses under this Plan for Basic hospital, surgical and medical care benefits, or

5. the scheduled amounts for other medical or vision benefits under this Plan.

Who Pays for What

To determine whether one plan is primary over the other, it is necessary to determine the order in which the various plans will pay benefits.

1. The plan which covers you as an employee or retiree will pay benefits before the plan which covers you as a family member.

2. The plan which covers you as an active employee or dependent will pay benefits before the plan that covers you under COBRA continuation coverage.

3. The plan which covers you as an active employee will pay benefits before the plan which covers you as a retiree.

4. For your dependent child, the plan that insures the parent whose birthday (month and day) occurs earlier in the calendar year will pay benefits first. When parents have the same birthday (month and day), the plan that has covered the dependent longer pays first (this rule does not apply if the other plan does not have this provision; in this case, the other plan shall determine the order of benefit payments).

5. For a dependent child, if you and your spouse are divorced or separated, benefits will be paid in the following order:

   (a) If the court has established one parent as financially responsible for the child's health care (through a Qualified Medical Child Support Order or "QMCSO"), the plan of the parent with that responsibility will pay benefits first;

   (b) Then, the plan of the parent who has custody of the child;

   (c) Then, the plan of the spouse of the parent who has custody of the child;

   (d) Then, the plan of the parent who does not have custody of the child.

6. If none of the above situations apply to you or your dependent, the plan which has covered you or your dependent for the longer period of time will pay before the plan which has covered you for a shorter period of time.

The Trust Fund has the right to obtain from and release to any insurance company, claims administrator, organization, or person, any benefit information necessary to determine whether the coordination provision applies.

Medicare and Your Benefits

If you are an active employee age 65 or older, this Plan will pay benefits first and Medicare will pay benefits second. The Plan will also pay benefits first for certain disabled employees entitled to Medicare. The same rule applies to your covered family members and organ transplant donors on your behalf. The Plan also pays benefits first for individuals receiving treatment for end stage renal disease (up to the first thirty (30) months of treatment.

If you are a retired employee over the age of 65 or a disabled retiree entitled to Medicare, Medicare will pay benefits first and the Plan will pay benefits second. The same rule applies to your covered family members and organ transplant donors on your behalf.

If you are entitled to Medicare benefits (either as result of turning age sixty-five (65) or total disability), you may elect Medicare as your primary plan by so notifying the Plan. If you do so, your medical coverage under this Plan will end.

This is the booklet describing ACTIVE benefits. RETIREE benefits are described in a separate Retiree Plan booklet. However, because if you are an Active employee planning for your retirement, you have important choices to make and for purposes of planning for your retirement, these choices as they relate to Medicare are described here. **If you are *retired*,** the Plan integrates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (supplemental medical benefits) whether or not you have applied for, or are enrolled in, Medicare benefits. ***This means if you do not enroll in Medicare, the Plan will not make up for the portion of expenses that Medicare would have paid had you enrolled.***

If you are an *active employee*, **the Plan integrates benefits with Medicare as if you are covered under Medicare Part A (hospital benefits) whether or not you have applied for, or are enrolled in Medicare benefits. However, you are not required to enroll in Medicare Part B (supplemental medical benefits) if you have acknowledged in writing that you are aware of the consequences of not enrolling in Medicare Part B by your 65th birthday. You can request a form for this purpose from the Trust Fund Office.**

<u>**Medicare Part D**</u>—if you are a Medicare-eligible retiree, you and your other Medicare-eligible family members *do not need to enroll in Medicare Part D* for prescription drug coverage as long as you are covered under the Health Care Plan. The prescription drug benefits you currently receive under the East Bay Drayage Drivers Security Fund are as good as or better than the standard Medicare Part D prescription drug coverage. Enrolling in Part D prescription drug coverage will increase your overall cost without giving you better benefits than the Plan provides, and will jeopardize your benefits under the Plan. As long as you have prescription drug coverage under the Plan, you are considered to have "creditable coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

Please note that whether or not you are advised to enroll in Medicare Part D, <u>you must still enroll for Medicare Part A (and Part B, unless you have filed a written acknowledgment with the Trust Fund Office)</u> in order to get full coverage in the Health Care Plan.

If you are enrolled in Kaiser or another HMO plan, please note that HMOs offer different plans to participants on Medicare.

Third Party Recovery

Right of Subrogation and Refund

When this provision applies. A Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party or the

Third Party's insurer, for payment of the medical or dental charges. The Plan's payment of benefits related to injuries caused by a Third Party gives the Plan an assignment of any rights of recovery you have against the Third Party or his/her insurer. This right of recovery (often referred to as "subrogation") allows the Plan to pursue any claim which the Covered Person has against any Third Party or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan also has a lien on any amount you recover, whether or not that amount was designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full, and any such recovery by the Covered Person, including any portion of the recovery designated for payment of attorney's fees, shall be held in constructive trust for the Plan up to the full amount of payments made by the Plan that it is entitled to recover.

What is a "Third Party" and when are they responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his/her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's "uninsured motorist" provision is a third party for this purpose.
- If you are injured in an auto accident and covered under a "no fault" provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's workers' compensation policy is the third party.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party.

The Covered Person:

1. must assign to the Plan his or her rights against any Third Party or insurer at the Plan's request when this provision applies; and

2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over *any* and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, benefit payments as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition of the Plan's payment of any claims related to the third-party injury. The Covered Person will do nothing to prejudice the right of the Plan to recover or subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person (or for a minor, his/her authorized representative) refuses to cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. The Plan may require a Covered Person to agree to acknowledge in writing the Plan's right to reimbursement before it will pay claims for expenses incurred because of an illness or injury for which a Third Party is (or may be) responsible. If a Covered Person fails to execute such papers or to reimburse the Plan, the Plan may deny payment of benefits and/or offset future benefits otherwise payable to or on behalf of the Covered Person against the amount to which it is entitled to be reimbursed until the full amount owed to the Plan is paid.

If you or your dependents fail or refuse to assist the Fund in recovering damages from a third party, the Fund may:

- Offset what is paid on your and/or your dependents' future claims against the claims paid for which the Fund should have been reimbursed because of the illness or injury caused by the third party until the Fund is completely reimbursed for the cost of these claims (including but not limited to costs incurred in collection); and
- File a lawsuit against you or your dependents to fully recover the amount the Fund should have been reimbursed; and/or
- Take any other action deemed appropriate by the Board of Trustees.

Defined terms:

"**Covered Person**" means any person covered under the Plan, including minor dependents.

"**Recoveries**" means all monies paid to, or to another party on behalf of, the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees (including fees paid directly to attorney), costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"**Refund**" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"**Subrogation**" means the Plan's right to pursue (through a lien or other means) the Covered Person's claims for medical or dental charges against the other person.

"**Third Party**" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan. The Plan has the right to request reports on and approve of all settlements before they become final.

Employment-Related Injuries or Illnesses

The Plan does not pay benefits for injuries or illnesses you or your family mem ber incurs on-the-job, subject to the following:

1. You or your family member will be presumed to be an employee of the employer (as defined under applicable Workers' Compensation laws), regardless of actual employment status.

2. This provision applies whether or not your or your family member's employer has Workers' Compensation insurance that pays for the particular medical expenses.

3. The Plan will pay benefits under the following conditions:

    a. If the Plan determines that it can collect the claim covered by a Workers' Compensation insurance policy or another collection arrangement.

    b. If you or your family member assigns to the Plan all rights to medical reimbursement under the applicable Workers' Compensation laws. When you or your family member accepts payment from the Plan, you also agree to allow the Plan to recover payments received from Workers' Compensation. You or your family member may be required to sign forms to that effect. Failure to sign the forms will make you or your family member ineligible for any Plan benefits related to the Workers' Compensation claim.

4. The Plan may intervene in any legal action you or your family member brings under the Workers' Compensation laws. In addition, the Plan may collect money directly from an employer or Workers' Compensation carrier by filing a lien on the proceeds with your or your family member's employer, its insurance carrier, its other agents, or the tribunal deciding Workers' Compensation claims.

5. If you or your family member settles or compromises a Workers' Compensation claim so that the amount the Plan is reimbursed is less than its lien, or so that the employer or its insurance carrier is relieved of any future liability for medical expenses, the Plan reserves the right to deny you or your family member any benefits in connection with the medical condition related to that Workers' Compensation claim.

6. When you or your family member accepts payment from the Plan, you also agree not to take any actions prejudicial to the Plan's rights to reimbursement under any applicable Workers' Compensation laws.

The Trust Fund Office's Right to Receive and Release Information

Certain facts are needed to administer these coordination of benefit, third party liability and Workers' Compensation rules. Each person claiming benefits under this Plan must provide any facts or information needed to pay the claim in question. In addition, you or your family member may be required to give written authorization to the Trust Fund Office to obtain the information it needs to complete a claim.

Overpayments and Right to Recover Benefits

The Plan checks all claims to be sure the patient is eligible for benefits and the services or supplies were provided. The Plan reserves the right to provide or obtain any information needed to determine benefits,

without the consent of any person. If an overpayment is made as the result of a coordination of benefits error or for any other reason, the Plan reserves the right to recover the amounts overpaid from you or from the benefit plan, insurance company, organization or provider to whom the overpayment was made. If an overpayment has been made to, or on behalf of, you or your spouse and you do not promptly pay back the overpaid amount to the Plan, the Plan may also recover the overpayment by deducting it from any future benefits payable to you or assigned by you. The Plan is not required, but reserves the right, to make restitution to another plan that has overpaid, and this payment is considered a benefit payment under the Plan made on your behalf.

Based on the specific circumstances particular to how a claim is submitted, the Plan may pay benefits before resolving whether or not such care is actually covered; this does not mean that the Plan exclusions were waived. If it is found that such a care is not covered, the Plan may require the covered person and/or provider of services to repay any overpayment.

If you submit false information in connection with a benefit claim, the Plan may in addition to seeking recovery of the overpayment, also withhold benefits otherwise payable to you and your family until it has recouped any overpayments made as a result of relying on the false information. **A false statement includes, but is not limited to, the concealment or omission of material information, such as a divorce, a child's loss of eligibility or change in marital status. It is not necessary that you did not intend to defraud the Plan for it to recoup overpayments in this manner.**

If the Plan does not follow these rules for a claim, this does not mean that the Plan has waived the Board of Trustees' right to invoke these rules for other claims.

Claims Processing

	Name & Type of Program	Who is Responsible for the Cost of Claims?	Who Processes Your Claims?
Medical	East Bay Drayage Drivers Security Fund Self-Funded Medical Plan	East Bay Drayage Drivers Security Fund	Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060 800-688-3828
Prescription	ElixirRx	East Bay Drayage Drivers Security Fund	ElixirRx Claims Department 2181 East Aurora Road Twinsburg, Ohio 44087 (833) 656-1506
Medical	Kaiser Permanente HMO Plan	Kaiser Permanente	Kaiser Permanente P.O. Box 1164 Oakland, CA 94606 (800) 464-4000
Dental	DeltaCare Dental Health Care Program	DeltaCare	DeltaCare USA P.O. Box 1810 Alpharetta, CA 30023 800-765-6003
Vision	Vision Service Plan	East Bay Drayage Drivers Security Fund	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-852-7600
Disability	Weekly Disability Plan	East Bay Drayage Drivers Security Fund	Corcoran Administrators P.O. Box 5030 Walnut Creek, CA 94596 855-263-7242
Life/AD&D	Life and AD&D Insurance Plans	Union Labor Life Insurance Company	Union Labor Life Insurance Company 180 Montgomery Street, Suite 1100 San Francisco, CA 94101 866-795-0680

Claims Procedure for Claims Not Involving a Determination of Disability

If you are enrolled with the Kaiser or Anthem Blue Cross HMO plans, you do not need to file claims for medical or prescription benefits unless you receive emergency or urgent care from a non-Kaiser or Anthem Blue Cross provider, in which case, you should submit a claim directly to Kaiser or Anthem Blue Cross.

If you receive services from a PPO provider, that provider will send a claim to the Plan on your behalf. If you must submit a claim yourself, claims for Self-Funded Medical Plan, prescription drug or dental benefits should be submitted on a claim form provided by the Trust Fund Office. The Trust Fund Office must receive your claim within 12 months of the date you receive the service or supply or it will be denied.

Each claim should include the full name of the patient, the diagnosis, the treatment date, the type of treatment or service received, and the doctor's name and address. Canceled checks or balance due bills are not acceptable. If the East Bay Drayage Drivers Security Fund is the secondary payor, you must submit a copy of the primary payor's explanation of benefits (EOB) form.

Information about the Claims Administrator for each benefit provided by the Plan, including address and telephone number, can be found in the "Directory of Benefits" on the previous page.

If You Must File a Claim Yourself

To have your claims covered you or your doctor or hospital must file a claim with the Plan. In general, claims will be filed automatically by your provider on your behalf. If not, you must send your medical bills and completed claim form to the Plan for reimbursement at the address listed on the back of your ID card. You may obtain a claim form from the Administrator.

When you complete your claim, be sure to follow the form's instructions, and include all required information to ensure timely processing. Contact the Plan directly at the toll-free number listed on your ID card if you need assistance in filing a claim.

Further information regarding claims determinations timeframes and claims appeal procedures can be found in the "Your Rights and Additional Information" section on page 92.

- **Pre-Admission Certification**

"Pre-Admission Certification" is a utilization review process which certifies the medical necessity and length of stay for any hospital confinement. Under the Plan, pre-admission certification is required for all non-emergency hospital admissions.

To complete the pre-admission certification process, you (or your medical provider) must notify the Trust Fund's Review Organization (ANTHEM BLUE CROSS) prior to any hospital admission by calling (800) 274-7767.

Pre-admission certification only determines the **medical necessity** of a service or supply according to the Plan benefits and provisions: it does not determine whether the treatment is **covered by the Plan. The fact that a hospitalization has been pre- admission certified does not mean the service or supply is fully or even partially covered.** To be covered, the hospitalization must also qualify as a covered expense. See "What The Medical Plan Covers" above.

For **Emergency Admissions** you must contact ANTHEM BLUE CROSS at the number listed above within seventy-two hours of admission.

Please Note: At the time of this printing, Anthem Blue Cross is the Fund's PPO provider and Pre-Certification Review organization. However, the Board reserves the right to designate another entity and, if so, will duly inform Plan participants and dependents.

Before the Plan pays benefits, the Trust Fund Office may ask you to be examined by a doctor of its choice. The Plan will pay for these examinations.

In most cases, the Plan will pay your benefits directly to your health care provider.

If an overpayment of a claim is discovered, you will be asked to reimburse the Trust Fund Office in the amount of the overpayment.

A claim will be considered to have been filed upon receipt by the Claims Administrator's Office (or other address listed on the claims form) provided that it contains all the necessary supporting documentation. If the form does not contain all necessary supporting documentation you will be informed what is missing and required to process the claim.

Claims for benefits must be submitted in writing within ninety **(90) days after the first date of service** (unless another date is given in this SPD). **Failure to submit a claim within ninety (90) days will not invalidate or reduce any claim if it is shown that it was not reasonably possible to submit the claim within ninety (90) days but was furnished as soon as reasonably possible. HOWEVER, IN NO EVENT, EXCEPT IN THE ABSENCE OF LEGAL CAPACITY, SHALL A CLAIM BE ACCEPTED LATER THAN ONE (1) YEAR FROM THE FIRST DATE OF SERVICE.**

Filing Claims for Health Care Benefits (Medical, Dental, Vision, Prescription Drug)

To file claims for any of the Plan's health care benefits, follow the procedures as described in this section. The claims procedure you follow will depend on whether your claim for benefits is a claim involving urgent or concurrent care, a pre-service claim or a post-service claim.

Pre-Service and Urgent Care Claims

A "Pre-Service Claim" is any claim for services not yet performed and which are not for urgent or concurrent care. An "Urgent Care Claim" is a claim for medical care or treatment where delay could seriously jeopardize your life or health or your ability to regain maximum function, or would, in the opinion of your physician, subject you to severe pain that can only be effectively managed through the requested course of treatment.

Filing an Initial Pre-Service Claim

The Claims Administrator will issue a decision within fifteen (15) days after receipt of the claim. If an extension is necessary, then a decision will be issued within thirty (30) days. You will receive written notice of the extension before the end of the initial 15-day period, which will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have up to forty-five (45) days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

Filing an Urgent Care Claim

The Claims Administrator will issue a decision within seventy-two (72) hours after receipt of the claim. If your claim is incomplete or you failed to follow the correct claims procedure, you will be notified within twenty-four (24) hours after receipt of the claim. You will then have up to forty-eight (48) hours to complete the claim. The Claims Administrator will issue a decision within forty-eight (48) hours after your deadline to complete the claim, or after receiving your completed claim, if sooner. If you do not provide the requested information within the 48-hour period, your claim will be denied.

Post-Service Claims

Any claim for health care benefits under the Plan that is not an Urgent Care Claim, a Pre-Service Claim, or a Concurrent Care Claim is considered a "Post-Service Claim."

Filing an Initial Post-Service Claim

The Claims Administrator will issue a decision within thirty (30) days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within forty-five (45) days. Written notice of the extension will be provided to you before the end of the initial 30-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have forty-five (45) days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

Concurrent Care Claims

In the case of a Concurrent Care Claim, where health care treatment is reduced or terminated before the end of the approved period of time or number of treatments, the Claims Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision and have the appeal decided before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non- urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Appeals Procedure for Claims

Not Involving Determination of Disability

Appealing A Denied Pre-Service or Urgent Care Claim

You (or your authorized representative) may appeal the denial of the claim. You (or your authorized representative) must file an appeal within one hundred eighty (180) days after your receipt of the notice of adverse decision. If you are appealing the denial of a Pre-Service Claim, the appeal must be made in writing. If you are appealing the denial of an Urgent Care Claim, you may request expedited review by telephone or in writing, and submit information in support of your appeal by facsimile and/or telephone, as appropriate. You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

The Board of Trustees will make the decision on appeal. They will not defer to the initial adverse benefit determination and will consider all comments, documents and records, and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made based on the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

You will receive notice of the decision on your appeal within thirty (30) days for Pre-Service Claims and within seventy-two (72) hours for Urgent Care Claims.

Appealing A Denied Post-Service Claim

You (or your authorized representative) may appeal a denial of the claim. You (or your authorized representative) must file a written appeal within one hundred eighty (180) days after your receipt of the notice of adverse decision. You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

The Board of Trustees will make the decision on appeal. They will not defer to the initial adverse benefit determination and will consider all comments, documents, and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made based on the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

Appeals of Post-Service Claims will be considered at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within thirty (30) days of the next regularly scheduled Board meeting, your appeal will be decided at the second regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the third regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five (5) days after a decision on your appeal is reached.

Legal Action Against Plan

You are not required to seek external review by an IRO and may instead challenge the Trustees' denial of an appeal by bringing legal action against the Plan within one year of the date you are informed your appeal has been denied. **No legal action challenging a claim denial may be brought against the Plan after the later of one year from (a) the date your internal appeal to the Board was denied or (b) the date the IRO determined the internal appeal was correctly decided.** You must exhaust your right of appeal described in this section before bringing suit against the Plan or Trustees. **The only court in which such lawsuits may be filed** is the United States District Court for the Northern District of California.

The Trustees have sole authority to interpret the provisions of the Plan and to interpret the rules and benefits of the Plan and their good faith interpretations of the rules, benefits and provisions of the Plan shall be final and binding, subject to the provisions of ERISA.

Plan Change or Termination

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan, the Plan's eligibility and other rules, the amount of contributions required for participation and all other aspects regarding the Plan.

Plan benefits and eligibility rules are not guaranteed or vested, may be changed or discontinued by the Board of Trustees, are subject to the rules and regulations adopted by the Board of Trustees, and are subject to the applicable collective bargaining agreements and the Trust Agreement which established and governs the Trust's operation.

Control Document

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

Claims and Appeals Procedure for Claims Involving A Determination of Disability

A claim for disability benefits is a request for disability plan benefits, including extended eligibility for coverage under the Plan for disabled participants or dependents under the Plan's extended eligibility or under COBRA, claims for the weekly disability benefit, or any other benefit dependent on a determination of disability (for purposes of this section, referred to as "disability benefits").

For disability benefit claim determinations and claim appeals, the people adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) will act independently and impartially.

Get a disability claim form from the Trust Fund Office, complete the patient portion of the form, then give the form to your physician to complete the health care provider section. Return the completed disability claim form to the Trust Fund Office (whose contact information is listed at the end of this document).

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability. Plan benefits will not be paid for any claim submitted after this period.

The Fund Administrator will determine your disability benefits claim no later than 45 calendar days after receipt. You will be notified if you did not follow the disability claim process or if you need to submit additional information or records to prove a disability claim and you have up to 45 calendar days to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the Fund Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period that additional time is needed to process the claim, the special circumstances for this extension, and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the Trust Fund Office determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. If the Trust Fund Office needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the claim for disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

(a) Give the specific reason(s) for the denial of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) Provide an explanation of the Plan's appeal procedure along with time limits;

(f) Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) Describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(h) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(i) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(j) Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Administrator to find out if assistance is available.

- <u>**Appeal of a Denial of a Disability Claim**</u>

If you disagree with a denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. You will be provided with:

(a) Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) Automatically and free of charge, provided any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

(e) Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date;

(f) If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

(g) A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and

(h) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) The specific reason(s) for the adverse appeal review decision of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(f) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(g) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(h) A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Fund Administrator for assistance.

Your Legal Rights and Administrative Information About the Plan

Compliance with HIPAA Privacy Regulations

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Human Services has adopted regulations for group health plans to treat health information of participants and beneficiaries as protected information. The application of those regulations to the Plan is summarized here. You may also request a copy of the Plan's Notice of Privacy Practices from the Trust Fund Office.

Information regarding a person's past, present or future physical or mental health, the provision of health care to that person, or past present or future payment for that person's health care, known as "Protected Health Information" (PHI), can be disclosed only to certain individuals for specific purposes.

The Plan Sponsor for the East Bay Drayage Drivers Security Fund is the Fund's Board of Trustees. The Board of Trustees consists of an equal number of Union and Management Trustees whose Unions, Companies and Associations are party to collective bargaining agreements that provide for participation in the Plan. The Plan Sponsors have final authority over Plan administration and operations, and in order to meet their obligations in this regard, must have access to PHI.

The Plan may use your health information, that is, information that constitutes protected health information ("PHI") as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996, 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.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Plan may use or disclose your health information 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.

The Plan may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a Union business agent or Employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Plan to speak to this person on your behalf. If you do not wish the Plan to release your health information to your spouse, family member or personal representative without prior written authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all Plan Participants. For example, the Plan may use your health information to conduct case

management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider who contacts the Plan to verify your eligibility.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

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

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The East Bay Drayage Drivers Security Fund is a jointly trusteed multiemployer trust fund that contracts with a third-party administrator for the day-to-day administration of the Plan. The Fund's Board of Trustees – not your Employer or Union – is the Plan sponsor. The Plan sponsor itself has no employees. The Plan Sponsor contracts with a third-party administrator to administer the Plan. As the Plan Sponsor, the Fund represents that adequate separation exists between the Plan and Plan Sponsor so that PHI will only be used for Plan administration.

The Plan may disclose your health information to the Board of Trustees for Plan administration functions performed by the Board of Trustees on behalf of the Plan, as described in 45 C.F.R. § 164.504(a), to the extent permitted under HIPAA regulations. Such administration shall include, but is not limited to, the following purposes: Appeals of Adverse Benefit Determinations, arranging for legal services, financial oversight, data analysis, COBRA administration, Coordination of Benefits, and Plan design. The Plan also may provide summary health information to the Board for the purpose of soliciting bids from health care providers and service plans or for the purpose of modifying, amending, or terminating the Plan. The Board of Trustees will not use or further disclose your PHI other than as permitted or required to carry out these purposes, or as otherwise required by applicable law. The Plan will not use or disclose your PHI for marketing purposes or in exchange for payment.

As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Plan, the Plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.

- Require each of its subcontractors or agents to whom the Plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the Plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plans sponsored by the Plan Sponsor, or an entity appointing a member of the Board of Trustees, e.g. a Union, Employer, or employer association, and not use or disclose the PHI for employment-related actions of an entity appointing a member of the Board of Trustees, e.g. a Union, Employer, or employer association.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining the Plan's compliance with the Privacy Rule.
- If feasible, return to the Plan or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

When Legally Required. The Plan will disclose your health information when it is required to do so by any federal, state or local law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Conduct Health Oversight Activities. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. The Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

Use and Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration and Operations

The Plan sponsor represents that adequate separation exists between the Plan and Plan sponsor so that PHI will be used only for Plan administration. As a jointly trusteed multiemployer trust fund which contracts with a third-party administrator, the Plan sponsor has no employees. No person under the control of the Plan sponsor has access to your PHI. The Plan may disclose your health information to the Plan sponsor for Plan administration functions performed by the Plan sponsor on behalf of the Plan. Such administration shall include, but is not limited to, the following purposes:

1. Deciding appeals of benefit denials and eligibility; establishing contribution rates; financial oversight; data analysis; making determinations regarding benefits, including whether or not to offer certain benefits and making plan design decisions; monitoring services provided by, and contracting with, HMOs, insurers, provider networks, and providers themselves (i.e., doctors and hospitals).

2. Dealing with subrogation and reimbursement claims involving third parties and participants; addressing coordination of benefit issues with other plans; purchasing stop-loss insurance and/or insurance to cover any of the benefits offered by the Plan.

3. Making decisions regarding the interpretation of plan documents as they relate to specific benefit claims, including decisions regarding medical necessity, disease management, standards of practice, and experimental treatments.

4. Providing for the collection of contributions from participating employers, including the auditing of such employers and the subsequent review of compliance audits to determine which employees and

dependents an employer has contributed for and if there are any for whom contributions are delinquent.

5. Addressing issues and appeals involving participants' legal rights, such as COBRA continuation coverage, HIPAA special enrollment periods, and HIPAA certificates of creditable coverage.

As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Plan, the Plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the Plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the Plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the Plan sponsor.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") for the purpose of determining the Plan's compliance with the Privacy Rule.
- If feasible, return to the Plan or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Disclosure of PHI to Plan Consultants

The Joint Board of Trustees acting as Plan Sponsor, undertake their responsibilities to the Plan on a voluntary basis. They are not employed by the Plan, nor does Plan or the trust fund have any employees. The Trustees and the Plan therefore utilize outside consultants to assist in all aspects of plan administration and operations, which requires the Plan to disclose PHI to them.

The consultants retained by the Plan include attorneys, benefit consultants, accountants, auditors, and the third-party administrator that administers the plan. Any or all of them may require access to PHI in order to advise and assist the Trustees. For example, the third-party administrator for the Plan, which processes all claims and verifies eligibility, will have access to PHI in carrying out these administrative functions. The auditor for the Plan determines if contributions have been correctly paid for all covered employees, and if ineligible persons were covered, whether claims were paid for them based on improper employer contributions.

Certifications, Restrictions and Limitations on the Use of PHI

The Plan, and the Plan Sponsor, hereby certify that they will:

a) Disclose PHI to the Plan Sponsor and its consultants only as set forth above and only the minimum amount necessary to enable them to fulfill their obligations to the Plan and its participants.

b) Report to the Plan any unauthorized disclosure of PHI or any use of PHI that is contrary to the purposes set forth herein. If the Plan Sponsor wishes to obtain access to PHI for purposes other than those set forth herein, it will seek written authorization from the participant(s) whose PHI is involved before the Plan allows access to the information.

c) Ensure that all consultants, attorneys, accountants, auditors, third party administrators, HMOs, insurers, or other Business Associates of the Plan agree in writing not to disclose or use PHI for any purpose contrary to law or to the terms of such written agreement with the Plan, and to otherwise comply with the requirements of the Privacy Standards with regard to the use and disclosure of PHI.

d) Make the PHI of any participant available to them pursuant to Section 164.524 of the Privacy Standards (45 CFR 164.524).

e) Not use or disclose PHI for employment related actions or decisions or in connection with any other non-group health employee benefit plan of the plan sponsor.

f) Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).

g) Make available an accounting of disclosures of PHI to any participant in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528).

h) Make the Plan's internal practices, books and records relating to the use or disclosure of PHI available to the Secretary of HHS for audit purposes.

i) If feasible, return or destroy all PHI received from the group health plan that the plan sponsor retains in any form when no longer needed for the purpose for which the disclosure was made.

j) Ensure that adequate separation between the group health plan and the plan sponsor exists to ensure the confidentiality of PHI.

k) Make no other disclosures or uses of PHI besides those permitted or required by the Plan Documents or as required by law.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information 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 Privacy Officer at the Plan Administration Office.

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 health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at the Plan Administration Office. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at the Plan Administration Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at the Plan Administration Office. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information 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 falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at the Plan Administration Office. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. 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 Paper Copy of the Notice. You have a right to request and receive a paper copy of the Privacy Notice at any time, even if you have received the Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the Plan Administration Office.

Duties of The Plan

The Plan is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the

terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy 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 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 to the Privacy Officer at the Plan Administration Office. 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.

Privacy Officer

The Plan has appointed a Privacy Officer, who is designated to ensure that this policy is followed and to address any issue or complaint regarding access to PHI for the Plan. Any participant or beneficiary who has a question or concern regarding the use of their PHI may direct their question or concern to: Privacy Officer, East Bay Drayage Drivers Security Fund, c/o Corcoran Administrators, P.O. Box 5030, Walnut Creek, CA 94596; telephone: (925) 954-1439 or (855) 263-7242. Participants and beneficiaries are also entitled to obtain an accounting of any disclosures of their PHI by the Plan. If they are not satisfied after communication with the Privacy Officer, they may direct any problem, concern or request to the Joint Board of Trustees, who will respond accordingly.

Effective Date

The Plan's privacy policies and procedures became effective September 1, 2016.

Security Rule Effective Date

The following are the Plan's security rules with regard to the creation, receipt, maintenance, storage and transmission of Protected Health Information ("PHI") via electronic means ("ePHI").

Use and Disclosure of ePHI. The Fund and its Plans may use and disclose ePHI, including ePHI for treatment, payment and operations, and such other uses and disclosures as are permitted and required under the HIPAA Privacy Rule and Security Rule, and the representatives of the Fund shall have access to such PHI, including ePHI, as is necessary for them to perform their duties for the Fund and its Plans.

Trustees' Use and Disclosure of ePHI. To the extent permitted by law, the Trustees may receive, use and disclose ePHI, if, in the sole discretion of the Trustees, such ePHI is necessary for the Trustees to perform their fiduciary or administrative duties as Trustees. In all cases, the Trustees shall receive, use and disclose the minimum amount of ePHI necessary for the Trustee to perform his or her functions under the Fund, and shall safeguard such ePHI as required by the Privacy and Security Rules. Each Trustee who receives ePHI from the Fund shall keep such information in strict confidence and shall not use or further disclose the ePHI received from the Fund other than as permitted or required by law and this Agreement or upon the express written permission of the Participant who is the subject of the ePHI.

Procedures. The Fund will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund, and will ensure the "adequate separation" within the meaning of 45 C.F.R. §164 504(f)(2)(iii) of the data.

Continued Coverage Under Family and Medical Leave Act

This Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 and its equivalent under state law, the California Family Rights Act (CFRA). Your employer will normally be covered by the FMLA if it employs at least 50 employees at one location, or at more than one location within a 75-mile radius, or by the CFRA if it employs 5 or more employees. If that is the case and if you meet the eligibility requirements under the FMLA and CFRA, your employer may be required to allow you to take up to 12 weeks of unpaid leave in a year due to your own serious medical condition or to care for a spouse, child or parent with a serious medical condition.

If you are off on FMLA/CFRA leave due to your own medical condition, this Plan will maintain your coverage for up to three (3) months at no cost to you, other than any employee contribution that you would normally pay. If you are off in order to care for a spouse, child or parent covered by FMLA or CFRA, your employer is obligated to pay for up to three (3) months of additional coverage for you, subject to your paying your normal contribution, if any.

It is not the role of the Trustees or Plan to determine whether an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and where applicable, the local union.

To the extent that Participants are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Plan will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer. Rights under this section do not affect your rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the Plan.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Plan asks that you not provide any genetic information when responding to requests for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) is a federal law that prevents large group health plans (such as this Plan) and health insurers (such as Kaiser) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical

benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at www.dol.gov/ebsa/mentalhealthparity/.

Your Rights Under USERRA

If you enter the U.S. military (except for reserve training), coverage for you and your dependents ends, unless you elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If you are engaged in full-time military service for more than thirty (30) days, you will no longer be eligible for life insurance benefits; however, you will have the option to convert your term life insurance policy into an individual policy. The U.S. Armed Forces may also provide coverage.

If you elect to continue coverage under USERRA, coverage may not extend beyond the earlier of:

- Eighteen (18) months beginning on the date the military leave of absence begins, or
- Twenty-four (24) months beginning after a military leave if you first made your election to continue coverage because of military service on or after December 10, 2004, or
- The day after the date you fail to apply for or return to work within the time required by USERRA.
- Your USERRA rights to continue coverage will run concurrently with your COBRA rights described on pages 68-73 of this booklet.

ERISA Rights and Administrative Information About the Plan

Rights of Participants and Beneficiaries

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to protect the interests of participants and beneficiaries in employee benefit plans.

As a participant in the 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:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Trust Fund 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Trust Fund Office, 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 make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Trust Fund Office is required by law to furnish each Participant with a copy of this Summary Annual Report.

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 (pension, welfare) benefit or exercising your rights under ERISA. However, this rule neither guarantees continued employment, nor affects your employer's right to terminate your employment for other reasons.

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 the above rights. For instance, if you request a copy of plan documents or the latest annual report form 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 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, and you have been through the Plan's appeal procedure, 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. 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.

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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

Your responsibilities

Your Mailing Address: It is your responsibility to keep the Plan Office advised of changes to your address so that you may continue to receive notices of important Plan changes that may affect your coverage or continue to receive Plan information. Changes must be made in writing by completing the appropriate Enrollment Form or Change of Address Form, both of which are available on the Plan's web page for the Plan. Please note: neither Kaiser nor Anthem Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either health plan.

Enrollment Form: Full completion and return of the Enrollment Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Plan Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (such as a marriage, separation, divorce, birth of child, Dependent status changes, Medicare eligibility or QMCSO). In addition, neither Kaiser nor Anthem Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either Health Plan. Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received.

Change in Dependent Status: Keep your enrollment form updated by adding a new Spouse or Child with any required proof, such as a marriage or Domestic Partner registration certificate, birth certificate or legal adoption papers. You must also notify the Plan Office if a Dependent ceases to quality as a Dependent, for example, due to divorce, death or the attainment of age 26.

Beneficiary Form: You should complete a Beneficiary Form at the time of initial enrollment. If you decide to change your Beneficiary, you must complete a new Beneficiary Form.

Protected Health Information (PHI): There are Privacy Rules to protect you based on the federal legislation known as the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information from the Plan Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Plan Office) and return it to the Plan Office.

Identification (ID) Cards: ID cards provide information but are not a guarantee of eligibility or benefits. Eligibility and benefits are verified on a month to month basis. Depending on the Health Plan selection elected on your Enrollment Form, you will be sent either a Kaiser ID card or Anthem Blue Cross ID card to access your Medical and Prescription Drug benefits. When you submit claims or correspondence to the Plan Office, you should include the last four digits of the Plan Participant's Social Security number. Please note: Vision claims should be submitted to Vision Service Plan (VSP).

Additional Information

Name and Address of Plan

East Bay Drayage Drivers Security Fund
c/o Corcoran Administrators
P.O. Box 5030

Walnut Creek, CA 94596
855-263-7242

Type of Plan: This is a Health Care Plan, providing eligible participants the following kinds of benefits:

Hospital, Medical and Surgical Benefits
Alcohol and Drug Treatment Benefits
Prescription Drug Benefits
Dental Benefits
Vision Care Benefits
Sleep Apnea Benefits
Disability Benefits
Life, Accidental Death and Dismemberment Benefits

IRS Employer Identification Number: 94-6073020

Plan Number: 501

Plan Year: The Plan's fiscal year ends on October 31.

Plan Administration

The Plan is administered by a Board of Trustees consisting of an equal number of Union and Employer Trustees. Union Trustees are representatives of Teamsters Union Local 70. Employer Trustees represent employers contributing to the East Bay Drayage Drivers Security Fund pursuant to collective bargaining agreements which provide for contributions to the Plan.

The Trustees have many powers and functions including adopting Plan rules and regulations to guide them in administering the Plan, interpreting Plan provisions and rules, amending the Plan, deciding questions of policy, investing and safeguarding Plan assets and appointing advisors and consultants, such as an auditor, benefits consultant, professional plan administrator, legal counsel and investment manager.

The Trustees have contracted with Corcoran Administrators, a professional plan administration firm, for the day-to-day administration of the Plan. The Trustees also use the services of a benefits consulting firm, Innovative Cost Management Services, to assist in determining the health care benefits provided under the Plan, among other responsibilities.

Type of Administration, Method of Funding, Contributions and Collective Bargaining Agreements

The Plan is funded and maintained through monthly contributions from participating Employers paid on behalf of eligible employees and their covered dependents pursuant to a collective bargaining agreement. You and/or your dependents may, upon written request, obtain a complete list of Employers and Unions sponsoring the Plan, or information regarding whether a particular Employer or Union participates in the Plan and, if so, their address. A copy of any of the collective bargaining agreements providing for participation in the Plan may be obtained from the Plan by written request addressed to the address listed above and is available for examination at the Administration Office during regular business hours. Assets of the Plan are held in trust, and benefits are funded through this Trust Fund.

Plan Funding and Contributions

The Plan is funded by monthly contributions from participating employers paid on behalf of eligible employees and their eligible dependents covered under collective bargaining agreements which provide for participation in the Plan.

The employer contribution is determined by the Board of Trustees under the authority of the East Bay Drayage Drivers Security Fund Agreement and Declaration of Trust and the collective bargaining agreements providing for contributions to the Trust Fund.

In certain circumstances, employees may be able to self-pay for a period of time when they are not covered by employer contributions. Plan assets are held in trust and benefits are funded through the Trust Fund.

Medical coverage (other than HMO coverage) and Life and Accidental Death and Dismemberment benefits are funded directly by the Trust Fund. HMO benefits are insured through the respective HMO plan as is the dental program offered through DeltaCare. All other benefits are funded directly by the Trust Fund, although the Fund may use a third party, such as, ElixirRx (for prescription drugs) or VSP (for vision benefits) to administer (pay claims, etc.) a specific type of benefit.

Plan assets are held in trust for the sole purpose of funding Plan benefits and paying the costs of Plan and Trust administration.

IMPORTANT NOTICE:

Notify the Union and the Plan Office immediately *if you believe that your Employer has not contributed and/or is not contributing the full amount on your behalf required under your Collective Bargaining Agreement. Please refer to your dispatch as a reference.*

Loss of Eligibility if no Contributions

You may lose eligibility with the Plan if Employer Contributions are not timely received by the due date for Employer contributions by the Plan Office.

Discretionary Authority of the Board of Trustees

The Board of Trustees reserves the right to make any determination of fact necessary or proper for the administration of the Fund and the Plan. Further, the Board has the power to construe and interpret the provisions of the Trust Agreement and the Plan including, but not limited to, those provisions of the Trust Agreement and/or the Plan relating to the eligibility of employees, retired employees, their dependents and beneficiaries, to receive benefits. Such determinations will be final and binding upon all parties, including employees, retired employees, their dependents and beneficiaries.

Deferral to Past Practice

The description of benefits contained in this booklet is intended as a summary of benefits and if this summary inadvertently omits reference to any long-standing Plan practice, such omission is not intended to indicate the Board of Trustees' intent to terminate such practice. In the event such an omission is discovered the Board will direct whether and how the Plan will conform to the omitted practice.

Future of the Plan

The Fund and Plan were established and are maintained through collective bargaining. The Board of Trustees anticipates the Fund and the Plan will continue for as long as collective bargaining agreements so provide, or until the bargaining parties elect to discontinue the Plan or the Fund.

Future amendments to the Plan may be made to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees. The Board of Trustees reserves the right to change or modify the Plan at any time for any reason without specific approval of any person. You will be notified if there are important amendments to the Plan through written notification. Before you decide to retire, you may want to contact the Plan Office to determine if there have been Plan amendments or other developments that may affect your retirement plan options.

Any change or modification of the Plan will not affect a claim incurred by an employee or dependent before the effective date of such change or modification.

If the Plan or Fund is terminated, the remaining assets will be used to continue to provide benefits until there are no assets remaining or will be used in a manner consistent with the purposes of the Plan. In no event will termination of the Fund or Plan result in a reversion of assets to any employer.

No Guarantee of Plan Benefits

Plan benefits are not guaranteed and there is no liability on the part of the Board of Trustees to provide payment over and above the amounts collected and available for such purposes. The Trustees reserve the right to change or discontinue the types and amounts of benefits described in this booklet and the eligibility rules in any manner in which they, in their sole discretion, determine to be prudent. 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.

The benefits available to active employees and retired employees may be changed or eliminated at any time by action of the Trustees.

Address of Board and Trust Fund Office:

Board of Trustees of the East Bay
Drayage Drivers Security Fund
c/o Corcoran Administrators
P.O. Box 5030
Walnut Creek, CA 94596

Telephone:

(925) 954-1439
(855) 263-7242

Members of the Board of Trustees

The names and business addresses of the members of the Board of Trustees are listed below.

EMPLOYER TRUSTEES	UNION TRUSTEES
Rich Murphy c/o Corcoran Administrators P.O. Box 5030 Walnut Creek, CA 94596	Marty Frates Teamsters Local 70 400 Roland Way Oakland, CA 94621
Deb Ostendorp c/o Corcoran Administrators P.O. Box 5030 Walnut Creek, CA 94596	Dominic Chiovare Teamsters Local 70 400 Roland Way Oakland, CA 94621
Greg Ong c/o Corcoran Administrators P.O. Box 5030 Walnut Creek, CA 94596	Felix Martinez Teamsters Local 70 400 Roland Way Oakland, CA 94621
Richard Valle c/o Corcoran Administrators P.O Box 5030 Walnut Creek, CA 94596	Mark Hawkins Teamsters Local 70 400 Roland Way Oakland, CA 94621

Agent for Service of Legal Process

You may direct legal process for the Plan to the following agent:

Board of Trustees of the East Bay Drayage Drivers Security Fund
c/o Corcoran Administrators
400 Roland Way
Oakland, CA 94621
or

any Plan Trustee

If You Have Questions

If you have any questions about the Plan, you should call the Trust Fund Office at:

(925) 954-1439 or (855) 263-7242

APPENDIX

Definition of Terms

The following definitions may be helpful when reviewing this Plan.

ACCIDENT, ACCIDENTAL INJURY

Physical injury resulting from a sudden, violent and external force which was not expected and could not have been reasonably foreseen or avoided.

ADMINISTRATOR, ADMINISTRATION OFFICE

The office of the Fund's contract administrator, Corcoran Administrators, should be used for purposes of any oral or written communications with the Trust Fund.

Corcoran Administrators
P.O. Box 5030
Walnut Creek, CA 94596
855-263-7242

ALLOWABLE AMOUNT

Maximum amount on which payment is based for covered health care services. This might be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

APPEAL

A request for your health insurer or plan to review a decision or grievance again.

APPLIED BEHAVIORAL ANALYSIS

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

AUTISM SPECTRUM DISORDERS

Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

BALANCE BILLING

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

CALENDAR YEAR

The period of twelve (12) consecutive months beginning with the first day of January.

CHIROPRACTIC CARE

Treatment provided, supervised or directed by a licensed chiropractor (including neuromuscular and physical medicine) incurred while under a licensed chiropractor's care, including such care prescribed by a medical doctor and performed by a physical therapist.

CO-INSURANCE

Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

COMPLICATIONS OF PREGNANCY

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

CO-PAYMENT

A fixed amount (for example, $15) you play for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

CONTRACT PROVIDER

"Contract Hospital" or "Contract Provider" means a hospital, facility, physician or other health care provider that has a contract in effect with the Preferred Provider Organization (PPO) under contract with the Plan.

CONVALESCENT HOSPITAL

A properly licensed institution that (1) meets the definition of an extended care facility under Title XVIII of the Social Security Act, as amended; (2) is primarily engaged in providing skilled nursing care and related services for injured, disabled or sick persons.

COPAYMENT

"Copay" and "Copayment" means the amount the eligible participant is required to pay for a service or drug before Plan benefits are payable.

COSMETIC SURGERY

Surgery that is not intended to correct normal functions of the body but is performed to improve the appearance of the patient or to preserve or restore a pleasing appearance. Cosmetic surgery is not covered under the Plan.

COVERED CHARGES

For PPO Network Hospitals and Doctors, the Network fee for medically necessary services, supplies and treatment for illnesses or injuries covered by the Plan. For Non-PPO Hospitals and Doctors, the Usual, Customary and Reasonable ("UCR") charges for medically necessary services, supplies and treatments for illnesses or injuries covered by the Plan.

COVERED INDIVIDUAL

An individual covered under this Plan.

COVERED TRANSPLANT PROCEDURE

Covered Transplant Procedure shall mean any of the following human-to-human organ or tissue transplants performed during a Benefit Transplant Period:

(a)	Bone Marrow	(e)	Lung
(b)	Heart	(f)	Kidney
(c)	Heart/Lung	(g)	Pancreas
(d)	Liver	(h)	Cornea

Experimental procedures for those transplants listed are *not* covered. In addition, no benefits will be payable by the Plan for the following:

a. Animal and/or mechanical organs except pumps and valves.

b. Any expense incurred for which the participant would not legally have to pay if there was no coverage for benefits.

c. Custodial care.

d. If an Employee or Dependent establishes a Benefit Transplant Period and subsequently loses coverage under the Plan, all benefit payments cease at the time coverage terminates.

e. Any organ or tissue transplant required as the result of an accidental injury or illness that is not covered by the Plan.

f. Unrelated donor search charges.

CUSTODIAL CARE

Custodial care means treatment, services or confinement which could be rendered safely and reasonably by a person not medically skilled, and which are designed mainly to help the patient with activities of daily life. Custodial care includes help in walking, getting in and out of bed, bathing, eating (including tube or gastronomy), exercising, dressing, using the toilet or administration of an enema, personal care such as homemaking services and preparing meals or special diets, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. *Custodial care is not covered under the Plan.*

DEDUCTIBLE

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. Your individual deductible under the Plan is $150, your plan won't pay anything until you've met your $150 individual deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Covered expenses incurred in the last ninety (90) days of a calendar year may be applied to the deductible for that year and toward the deductible for the following year as well.

DENTIST

A Dentist is a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

DEPENDENT

Your,

- legal spouse or domestic partner; and
- children, stepchildren and legally adopted children, children placed with you for adoption, or children for whom you have been appointed legal guardian by court order, under age twenty-six (26).

Effective August 1, 2010, "children" meeting the definition above under age twenty-six (26) are under no obligation to be dependent on you (for federal or state tax purposes or otherwise) or enrolled full-time in school to remain eligible for the Plan as a "dependent." However, a child who is covered in his/her own employer-provided health care plan is ineligible for coverage as a dependent in this Plan.

No one other than those described above qualify as dependents.

DISABILITY, TOTAL

A total disability is a physical or mental condition for which you need a doctor's care which satisfies the following additional requirements.

Disabilities related to commission of a felony, or due to injury or illness related to military service, do not qualify as total disabilities. "Totally disabled" has different meanings depending on whether you are covered as a Plan participant ("covered employee") or a dependent.

- If you are a covered employee you will be considered totally disabled while, as a result of bodily injury or illness, you are prevented continuously from engaging in any occupation for which you are qualified by reason of education, training or experience.
- If you are covered as a dependent you will be considered totally disabled while, as a result of bodily injury or illness, you are unable to engage in your regular and customary activities and are not engaged in any occupation for wages or profit.

Note that a different definition of disability applies to COBRA continuation coverage.

DOMESTIC PARTNER

A dependent who meets the eligibility requirements described on page 4.

DOCTOR

Also referred to as "physician." An individual licensed as a Doctor of Medicine ("M.D.") or Doctor of Osteopathy ("D.O."). Also includes any licensed or certified health care provider, as required by state law, for services which are:

- Within the scope of the health care provider's license or certificate, and
- A covered medical expense.

DURABLE MEDICAL EQUIPMENT (DME)

Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

EMERGENCY CARE

An emergency is defined by the Plan as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) a condition placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Examples of emergency conditions are:

- severe chest pain
- uncontrolled bleeding
- loss of consciousness
- severe shortness of breath
- poisoning
- sudden onset of paralysis and/or slurred speech
- severe burns
- broken bones

Care will not be considered to be an emergency unless it is sought and given immediately (usually within 24 hours) after the sudden onset of symptoms.

EMERGENCY MEDICAL CONDITION

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

EMERGENCY MEDICAL TRANSPORTATION

Ambulance services for an emergency medical condition.

EMERGENCY ROOM CARE

Emergency services you get in an emergency room.

EMERGENCY SERVICES

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EXCLUDED SERVICES

Health care services that your health insurance plan doesn't pay for or cover.

EXPENSE INCURRED

The fees and prices regularly and customarily charged for medical services and supplies generally furnished for cases of comparable natures and severity in the particular geographic area concerned. An expense is considered to be incurred on the date the service or supply is rendered or obtained.

EXPERIMENTAL OR INVESTIGATIVE SERVICES

Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that has not been,

- Recognized as conforming to safe and accepted medical or health practice;
- Fully subject to scientific assessment as to its effectiveness for the condition in question;
- Fully approved by a federal government agency at the time the services were rendered.

GENERIC DRUG

A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

GRIEVANCE

A complaint that you communicate to your health insurer or plan.

HABILITATION SERVICES

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH INSURANCE

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

HOME HEALTH CARE

Services provided in a covered person's home under the following conditions:

- The covered person was confined in a hospital or skilled nursing facility prior to the commencement of home health care services;
- Continued confinement in a hospital or skilled nursing facility would have been required if home health care services were not provided;
- A home health care treatment plan is established and approved by a doctor within fourteen (14)

days after discharge from the hospital, and such treatment plan is for the same and related condition for which the covered person was confined; and
- Home health care services commence within fourteen (14) days following discharge from the hospital or convalescent hospital, after a hospital or convalescent confinement of at least five (5) days.

HOME HEALTH CARE AGENCY

A private or public agency or organization licensed as a home health agency.

HOME HEALTH CARE SERVICES

Home health care services consist of, but are not limited, to:

- Part-time or intermittent home nursing care provided by a Registered Nurse or Licensed Practical Nurse under the supervision of a Registered Nurse, if the services of a Registered Nurse are not available;
- Part-time or intermittent home health aide services which consist primarily of medical or therapeutic care for the patient by other than a Registered or Licensed Practical Nurse; Physical, occupational or speech therapy, if provided by the home health care agency;
- Medical supplies, drugs or medicines prescribed by a doctor and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Plan if the covered person had remained in the hospital or a skilled nursing facility.

HOSPICE

A health care facility that provides a hospice care program in a separate facility and admits at least two (2), but not more than eight (8), patients who are unrelated, have no reasonable prospect of a cure, and have a life expectancy of not more than six (6) months.

HOSPICE CARE PROGRAM

A coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of terminally ill patients and their families.

HOSPICE CARE SERVICES

Palliative care for terminally ill patients. 'Palliative care' is care that is rendered to relieve the symptoms or effects of a disease without curing the disease. Refers to any services that a hospital, related institution, home health care agency, hospice or other licensed facility provides under a hospice care program. Services to provide comfort and support for persons in the last stages of a terminal illness and their families

HOSPITAL

An institution that:

- Is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick persons;
- Maintains clinical records on all patients;

- Has bylaws in effect with respect to its staff of physicians;
- Has a requirement that every patient be under the care of a physician;
- Provides 24-hour nursing service rendered or supervised by a registered professional nurse;
- Has in effect a hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, nursing facility, convalescent facility, residential treatment center or facility for the aged or the care and treatment of alcohol and substance abuse, except as mandated by state law, or any institution that makes a charge that the patient would not be legally required to pay in the absence of this Plan. The following describes two levels of inpatient care:

1. Acute Care. The acute level of care is for a patient with a medical condition that requires:

   a. A continued availability of medical supervision and/or other medical consulting staff.
   b. The continuing availability of licensed nursing personnel.
   c. The immediate availability of other diagnostic or therapeutic services and equipment present only in acute care facilities.

2. Sub-acute Level of Care. The sub-acute level of care is an alternative to acute care for inpatient medically stable patients who require intense, highly technical services. The programs (or units) provide comprehensive medical, nursing and rehabilitative services (and can include all other modalities of care found at the acute level of care) using an integrated interdisciplinary approach.

HOSPITAL OUTPATIENT CARE

Care in a hospital that usually doesn't require an overnight stay.

HOSPITALIZATION

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

HOSPITAL MISCELLANEOUS CHARGES

Those covered charges made by the hospital for charges other than room and board. Miscellaneous charges include, but are not limited to, diagnostic radiology and pathology, including the professional services in connection with radiology and pathology, the operating room, radiation therapy and medically necessary drugs and medical or surgical supplies, and the use of hospital equipment while the patient is confined to the hospital.

ILLNESS

A disorder or disease of the body or mind. "Illness" includes pregnancy, childbirth and related conditions.

INJURY

Bodily harm that is not the result of disease.

IN-NETWORK CO-INSURANCE

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

IN-NETWORK CO-PAYMENT

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

INPATIENT

Treatment provided while an individual is confined as a bed patient in a covered facility.

MEDICALLY NECESSARY

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

MEDICALLY NECESSARY SERVICES AND SUPPLIES

Services or supplies which are provided by a hospital, doctor or other approved provider and which are determined by the Plan to be:

- Appropriate and reasonably required for the diagnosis, treatment or management of a medical symptom, illness, injury or condition and are not cosmetic in nature;

- The most efficient and economical service which can safely be provided for the diagnosis or the direct care and treatment of the illness, injury or condition;

- Generally recognized in the treating physician's area of specialization as effective and essential to the treatment of the injury or illness for which it is ordered;
- The appropriate level of care, and which:
  - Is approved in the most appropriate setting, based on the diagnosis and condition, and
  - Could not have been omitted without an adverse effect on the covered person's condition or the quality of medical care;
- Based on generally recognized and accepted standards of medical or dental practice in the United States;
- Not primarily for the comfort, convenience, or administrative ease of the doctor or other health care provider, or the covered person or his/her family or caretaker;
- Not considered experimental, investigatory, or primarily limited to research in its application to the injury or illness;
- Not primarily for scholastic, educational, vocational or developmental training; and
- Not custodial care.

Furthermore, the fact that a doctor or dentist may prescribe, order, recommend or approve a service or supply does not of itself make such a service or supply medically necessary, even though it is not specifically listed as not covered by the Plan. Medical necessity also applies to the type of facility in which

you receive care, and the level of care. The Plan does not consider hospitalization medically necessary if the care could be adequately provided in a less expensive facility such as a skilled nursing facility, outpatient clinic, or at home.

MEDICARE

Medical benefits provided by Title XVIII of the Federal Social Security Act, as amended.

MENTAL ILLNESS OR DISORDER

The term "Mental Illness or Disorder" means any mental illness or disorder, whether the cause is organic, physical, mental or environmental, or any combination thereof, or whether the symptoms are physical, mental or a combination thereof. Conditions that affect thinking, perception, mood or behavior. Such conditions are recognized primarily by psychiatric symptoms that appear as distortions of normal thinking or perception, moodiness, sudden or extreme changes in mood, depression or unusual behavior such as depressed behavior, highly agitated or manic behavior, physical manifestations.

Any condition meeting this definition is included in it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination of both.

Examples of mental illnesses or disorders include (but are not limited to) those which fall within the diagnosis codes F0390 or F05 through F609 or F458 through F54 as listed in the "International Classification of Diseases," 10th Revision, Clinical Modification, such as: schizophrenia, manic depression and other conditions usually classified in the medical community as psychosis; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post-traumatic stress disorder; cumulative trauma syndrome; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

NON-PREFERRED PROVIDER

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

ORTHODONTIA

Movement of and/or straightening of teeth to correct malocclusion.

OUT-OF-NETWORK CO-INSURANCE

The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

OUT-OF-NETWORK CO-PAYMENT

A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

OUT-OF-POCKET LIMIT

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. The limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

OUTPATIENT

Treatment that is provided when the individual is not confined overnight in a covered facility. This includes outpatient treatment at a covered facility as well as visits to a doctor or other covered health care provider.

OUTPATIENT SURGICAL CENTERS

An outpatient surgical center is considered a hospital if the outpatient surgical center meets the following conditions:

1. The center must meet the basic definition of a hospital, other than providing overnight facilities and the 24-hour nursing services.
2. The facility must be licensed or AHC certified as an outpatient surgical center.
3. The center must have an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, and with continuous physician services and registered professional nursing services whenever a patient is in the facility, and must not provide services or other accommodations for patients to stay overnight.

PARTIAL HOSPITALIZATION/DAY TREATMENT

The partial hospitalization/day treatment level of care is an alternative to acute inpatient psychiatric care. Patients in this setting require an intensive treatment structure for 4 to 8 hours per day but are able to return to a supportive home environment at night.

PHYSICIAN OR DOCTOR

Physician or doctor means, with respect to any particular medical care and surgical services, any holder of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. The term "physician" shall not include the eligible employee or dependent; or the spouse, parent, child, sister or brother of the eligible employee or dependent.

PHYSICIAN SERVICES

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

PLAN

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

PREAUTHORIZATION

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

PREFERRED PROVIDER

A provider who has a contract with your health insurer or plan to provide service to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

PREFERRED PROVIDER ORGANIZATION (PPO)

Preferred provider means a doctor, hospital, outpatient surgical center or laboratory rendering services at reduced rates in accordance with the agreement with the Preferred Provider networks, including Anthem Blue Cross for the hospital and physician network, ElixirRx for the pharmacy network, and TAP for substance abuse. A directory of preferred providers may be obtained from the Trust Fund Office.

No health care provider is an agent or representative of the Plan. The Plan does not control or direct the provision of health care services and/or supplies to plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind concerning the skills or competency of any health care provider. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the Plan to provide utilization review or to offer HMO coverage, preferred provider networks or other health-related services or supplies to

participants and beneficiaries, including but not limited to Anthem Blue Cross, ElixirRx, TAP, and Kaiser Permanente.

Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

PREMIUM

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

PRESCRIPTION DRUG COVERAGE

Health insurance or plan that helps pay for prescription drugs and medications.

PRESCRIPTION DRUGS

Drugs and medications that by law require a prescription.

PRIMARY CARE PHYSICIAN

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

PRIMARY CARE PROVIDER

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

PROVIDER

A physician, health care professional or health care facility licensed, certified or accredited as required by state law.

1. A licensed Medical Doctor (M.D.)
2. A licensed Doctor of Osteopathy (D.O.)
3. A Chiropractic Doctor (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.)
5. A Doctor of Dental Surgery (D.D.S.)
6. A Doctor of Podiatry (D.P.M.)
7. A Physical Therapist.
8. A Psychologist (Ph.D.)
9. A Master of Social Work (L.C.S.W., M.S.W., and M.F.C.C.)
10. An Ophthalmologist (M.D.) or an Optometrist.
11. A Certified Nurse Anesthetist.
12. A Registered Nurse as First Assistant (R.N.F.A.), under the supervision of a Medical Doctor.
13. A Physician Assistant (P.A.)
14. A licensed Midwife.

A provider does not include a person who lives in your home or who is related to you by blood or marriage.

QUALIFIED MEDICAL SUPPORT ORDER

A medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible.

When the Plan receives a child support order it will be reviewed and if the Plan determines that the order is a Qualified Medical Child Support Order ("QMCSO"), the child's enrollment as a dependent in your Plan will be automatic. If the order was issued in the form of a "National Medical Support Notice" and is subsequently determined to be qualified, you (and your child) will automatically be enrolled in the Plan option chosen by the applicable state child support enforcement agency. You may obtain detailed information on the Plan's procedures governing QMCSO determinations, without cost, from the Administrator's Office.

RECONSTRUCTIVE SURGERY

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

REHABILITATION SERVICES

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in variety of inpatient and/or outpatient settings.

ROOM AND BOARD CHARGES

Charges made by a hospital or skilled nursing facility for the room, meals, and routine nursing services for covered individuals confined as bed patients.

SKILLED NURSING CARE

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home. This level of care provides inpatient care for a person with a medical condition requiring services by or under the direct supervision of licensed personnel under the general direction of a physician, which is needed to assure the safety of the patient or to achieve the medically desired result. In this level of care, the patient's medical needs require the availability of skilled nursing services on a continuing basis but not the constant availability of the medical services of an acute hospital. The patient's condition is <u>not yet stabilized</u> and he/she is receiving one or more skilled or rehabilitative services.

SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

SPEECH THERAPIST

Someone who has a master's degree in speech pathology and has completed an internship and is licensed by the state in which he or she performs his or her services, if that state requires licensing.

TOTAL DISABILITY

See "Disability, Total"

TREATMENT

A treatment or course of treatment which is ordered and/or provided by a doctor to diagnose or treat an injury or illness including:

- Confinement and inpatient or outpatient services or procedures, and
- Drugs, supplies, equipment or devices.

UCR (USUAL, CUSTOMARY AND REASONABLE)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

ULLICO

The Union Labor Life Insurance Company.

URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES

Usual, Customary and Reasonable means the amount the Plan allows as payment for eligible Medically Necessary Services or supplies.

- With respect to a Preferred Provider Organization (PPO), the negotiated fee/rate set forth in the agreement between the PPO and the Preferred Provider network or the Plan. If such an agreement does not contain a negotiated fee/rate or a method for determining the payable amount, the charge shall be treated as though submitted by a non-PPO provider.

- With respect to a non-PPO provider, the Usual, Customary and Reasonable amount is determined by the Plan or its designee to be the lowest of (1), (2), or (3) below that the Plan has determined it will allow for eligible Medically Necessary Services or supplies performed by non-PPO providers.

    1. The provider's actual billed charge.
    2. The prevailing charge made by other providers of similar professional standing within the same or a similar geographic area for that treatment.

3. For medical claims incurred in the United States, the Plan has adopted for this purpose the schedule used by Anthem Blue Cross CNR to determine the customary and reasonable charge applicable to non-PPO providers.

If the usual or prevailing charge cannot be determined, the Plan will determine what is a reasonable charge, taking into account:

- Any unusual complications of the injury or illness,
- The complexity and degree of professional skill required, and
- Other factors deemed pertinent by the Plan.

- For a PPO provider whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Usual, Customary and Reasonable amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a PPO claim.

Except as noted above, the Plan's Usual, Customary and Reasonable amount applicable to non-PPO providers is not based on or intended to be reflective of fees that are or may be described within the healthcare industry as usual and customary (U&C), reasonable and customary (R&C), prevailing or any similar term. The Plan's definition of Usual, Customary and Reasonable set forth above shall prevail to the extent it conflicts with any other usage of "usual, customary and reasonable charge" or "UCR" used in the healthcare industry. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

UTILIZATION REVIEW

Review of your treatment by the Plan's representative after treatment has begun. For hospital visits, acute inpatient care must be necessary for the treatment received or the seriousness of the patient's condition. If safe and effective care is available as an outpatient or in an alternative medical setting, the Plan will pay for the less expensive treatment.

YOU

The words "you" and "your" as used in this booklet are intended to refer to the covered employee/Plan participant.