

EAST BAY DRAYAGE DRIVERS SECURITY FUND

Summary Plan Description For Retirees



January 1, 2016

Dear Retiree:

Teamsters Local 70 and your employer have worked together to provide you with a comprehensive program of health benefits for retired employees. This booklet, known as a Summary Plan Description, provides general information and guidelines regarding the East Bay Drayage Security Fund and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Administration Office at (855) 263-7242.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, employer, or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

The Board has authorized the Administration Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Administration Office. The address for the Plan is:

**P.O. Box 5030
Walnut Creek, CA 94596
(855) 263-7242**

As a courtesy to you, the Administration Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. The Board of Trustees may reduce or eliminate any benefits provided under the Plan (or any insurance policy, HMO or other entity) at any time. Retirees and their dependents may also be required to make additional contributions for any cost increases to the Plan.

If there are important changes to the information in the Summary Plan Description, the Plan will provide you with a summary of material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them. The benefits in this Summary Plan Description state the terms of the Retiree Plan as of January 1, 2016. Any subsequent amendments will govern the actual benefits payable.

PLAN BENEFITS ARE NOT GUARANTEED

Plan benefits for retired employees 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 Retiree Plan, including benefits 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 Retirees may be changed or eliminated at any time by action of the Trustees or by action of the participating employers and the Union. A change or termination of benefits will apply to individuals who have already retired as well as to future retirees. **There is no vested right to receive benefits under this Plan.**

Please note, the East Bay Drayage Drivers Security Fund's Plan of Benefits for Retired Employees described in this booklet is a retiree-only plan under the terms of the Employee Retirement Income Security Act of 1974 ("ERISA") and the Patient Protection and Affordable Care Act of 2010 ("PPACA"). As a retiree-only plan it is not subject to many of the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the PPACA applicable to group health plans for active employees.

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 understanding any part of this booklet, you may contact Corcoran Administrators - P.O. Box 5030, Walnut Creek, CA 94596 (855) 263-7242.

Aviso En Español

Este folleto contiene un resumen en inglés 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 al número de teléfono (855) 263-7242.

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ELIGIBILITY

Who is Eligible?

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.

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:

- Effective August 1, 1997, retirees with fewer than 10 years of coverage in an East Bay Drayage Drivers plan for Active employees are not eligible to participate in the Retiree Plan.

If you retire on or after **August 1, 2003**:

- 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 10 years of coverage under the an 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. As of August 1, 2003, the date you apply for retiree health benefits is no longer relevant to whether you meet the eligibility tests. Please review your Retiree Application or contact the Administration Office for the most current schedule of co-payment rates.*

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.

Termination of Eligibility:

Your eligibility and the eligibility of your dependents automatically terminate on the earliest of one of the following:

- The date of your death;
- The 90th day for which any self-payment is delinquent;
- The date upon which you become actively employed and continue such employment for 80 hours or more within any month. However, your coverage under this Retiree Plan will continue for any waiting period required by your new group benefit plan before qualifying for benefits for which you are eligible as an active employee;
- The date upon which this Retiree Plan and/or this Trust Fund terminates; or
- The date the employer for whom you worked at the time of retirement withdraws from participation in the Fund but remains in business. However, you may be allowed to continue coverage if your former employer continues contributions on your behalf in an amount determined by the Trustees or if you make full payment for the full cost of

coverage. In this event, the Trustees shall have authority to terminate such retirees or to maintain eligibility on such terms and conditions as the Trustees shall adopt.

For information on COBRA continuation coverage see page 6.

Reinstatement of Eligibility:

In the case of covered retirees who lose coverage because they return to active employment, reinstatement in this Plan will be automatic if their active employment did not exceed 12 months. Retirees who for any other reason terminate their eligibility under this Plan will not be permitted to reapply for coverage thereafter.

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 unmarried children, up to age eighteen (18), who depend primarily on you for support, including stepchildren, legally adopted children, children placed with you for adoption, or children for whom you have been appointed legal guardian by court order; your unmarried children, up to age twenty six (26) who are full-time students in high school or an accredited college or university, and who depend primarily on you for support; and
- Your unmarried mentally or physically handicapped children 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 eighteen (18) and at any other time requested by the Fund).

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; or
- On the date that you have fully completed the requirements described under the heading “Application Process for Domestic Partner Coverage.”
- **If you are married at the time of your retirement and elect single coverage you will not be able to add your spouse or eligible dependents at a later date.**

Domestic Partners

Eligibility of Domestic Partners:

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

Test #1: Your domestic partner qualifies for coverage if you have a valid *Certificate of Domestic Partnership* issued by the California Secretary of State pursuant to California Family Law Code section 298. Under California law, you are eligible for such a *Certificate* if you and your **same sex** domestic partner meet the following conditions:

- Share a place of residence;
- Are jointly responsible for each other's common welfare and financial obligations; and
- Are unmarried, legally competent in the State of California to enter into a contract, eighteen (18) years or older, and are not blood relatives.

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

Test #2: If you and your domestic partner are of the **opposite sex** and you are younger than age sixty two (62), the following rules apply:

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

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

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 on the first day of the month immediately following completion of the six-month waiting period described above, under Test 2, *provided* that you remain eligible for coverage as of that date.

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 retiree's eligibility terminates; or
- The date dependent coverage would otherwise terminate under the terms of the Plan.

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.

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 a child unless you submit written evidence that the child support order is no longer in effect. A copy of the Fund's procedures for determination of whether a child support order satisfies the requirements of a QMCSO is available on request.

When Coverage Ends for QMCSO Dependents:

Coverage for your dependents generally ends on the earliest of the following:

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

COBRA CONTINUATION COVERAGE

Extension of Coverage by Self-Payment – COBRA:

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that requires the Fund to allow your dependents the opportunity to continue health coverage at their expense when their coverage under this Plan ends. When you retired, you were offered a choice between electing a temporary continuation of group health coverage ("COBRA Continuation Coverage") or electing Retiree health coverage. As you elected this Plan's Retiree health coverage, you will have no further COBRA continuation rights (with the exception of certain circumstances related to bankruptcy - see page 8). However, your dependents may experience a COBRA Qualifying Event as described below. To choose COBRA coverage, your dependent must be covered under the Plan on the day before the qualifying event. Please note that your domestic partner and his/her eligible dependents are not eligible for COBRA.

Dependents' COBRA "Qualifying Events":

If your dependent experiences a COBRA Qualifying Event he or she may elect to continue coverage.

Your dependents become eligible for COBRA for the following reasons:

- You die;

- You divorce your spouse (this is a “qualifying event” for your divorced spouse only - it does not result in a loss of coverage or COBRA “qualifying event” for your dependent children because they do not lose coverage as a result of your divorce); or
- When your dependent child ceases to be eligible for coverage under the terms of the Plan (e.g., your child reaches the maximum age limitation).

COBRA Notification Requirement:

If your Plan coverage ends because of your death, your dependents will receive information from the Administration Office regarding their COBRA coverage rights within thirty (30) days of your death. They will have sixty (60) days to elect COBRA coverage.

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

COBRA Coverage Options:

The Plan’s COBRA premium is a “comprehensive” – rather than single or family – premium for the Retiree and spouse. Therefore, if you or your spouse elects and pays for COBRA coverage, that COBRA election will cover your eligible dependents. If, however, a dependent child has a COBRA qualifying event and elects COBRA, their COBRA premium will cover only that child.

COBRA Coverage Period:

COBRA coverage begins on the date your dependent loses health care coverage because of a qualifying event and lasts up to thirty six (36) months.

Cost of COBRA Coverage:

Your dependents must pay the full cost of coverage, plus a 2% administrative fee.

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

If your dependent elects COBRA coverage, his or her initial premiums are due by the 45th day following the election date. The initial premium payment must include the premiums for coverage from the date coverage under the Plan ended. Your dependent must pay additional premiums in monthly installments due on the first of the month; however, he or she will be allowed a 30-day grace period for subsequent monthly premium payments. The Fund cannot confirm that your dependent will be covered in any month until or unless it has received his/her monthly payment.

Your dependent’s COBRA coverage will terminate if he or she does not make his or her premium payment before this grace period ends.

When COBRA Coverage Ends:

Your dependents' COBRA coverage terminates as of the earliest of the following dates:

- The end of the 36-month COBRA coverage period;
- The date a COBRA payment is delinquent in excess of thirty (30) days;
- The date your dependent becomes covered by another group health plan;
- The date a person on COBRA coverage becomes entitled to Medicare; or
- The date the Plan ends.

COBRA Rights in the Event of Bankruptcy of Former Employer:

A retiree and his/her covered dependents are entitled to pay for COBRA coverage until the retiree's death, if the Retiree loses his/her Plan coverage because his/her former employer filed for Federal bankruptcy under Chapter 11 and his/her Plan coverage was substantially reduced or eliminated within the twelve (12) month period preceding or following the commencement of this bankruptcy action.

Keep the Administrator Informed of Address Changes:

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

BENEFIT OPTIONS

Your Coverage:

Under the Retiree Plan your coverage options will depend on whether you and/or your dependents are eligible for Medicare.

- If you **are not** Medicare-eligible see pages 10-23 for your Benefits Summary.
- If you **are** Medicare-eligible see pages 24-28 for your Benefits Summary.

Your Spouse's Coverage:

Your spouse's coverage options are limited by the coverage option you select:

- *If you and your spouse **are both** Medicare-eligible*
 - You and your spouse will have the same coverage (see pages 24-28).
- *If **neither you nor your spouse** is eligible for Medicare*
 - You and your spouse will have the same coverage (see pages 10-23).

- *If **you are** eligible for Medicare but your **spouse is not***

Your spouse's coverage option will depend on the coverage option you select:

- If you select Kaiser Senior Advantage your spouse will be enrolled in the Kaiser HMO option;
- If you select TeamSTAR/Teamster Plus your spouse will be enrolled in the Anthem PPO option.

- *If **you are not** eligible for Medicare but your **spouse is** eligible for Medicare*

Your spouse's coverage option will depend on which coverage option you select:

- If you select the Anthem PPO option then your spouse must enroll in TeamSTAR/Teamster Plus;
- If you select the Anthem HMO option then your spouse must enroll in TeamSTAR/Teamster Plus;
- If you select the Kaiser HMO option then your spouse must enroll in Kaiser Senior Advantage.

Coverage for Dependents Other Than Your Spouse:

The same rules apply as are described above for a spouse.

BENEFITS SUMMARY FOR RETIREES NOT YET ELIGIBLE FOR MEDICARE
(“Early Retirees”)

If you are Medicare-eligible this section does not apply to you. Please see page 24.

BENEFIT OPTIONS for EARLY RETIREES (NOT YET ELIGIBLE FOR MEDICARE)			
Benefit	Anthem Blue Cross PPO	Anthem Blue Cross HMO	Kaiser HMO
Annual Medical Deductible Starts on January 1 st each year	\$300 Per Individual	None	None
Annual Out of Pocket Maximum	\$2,000 Per Individual after deductible	\$1,500 Individual/ \$3,000 Family	\$1,500 Individual/ \$3,000 Family
Maximum Lifetime Benefit	\$1,000,000	None	None
Preventative Care: Routine preventative exam Prenatal Care Immunizations Preventative Tests	Not covered except for children under 17	\$0	\$5 per visit
Inpatient Hospital Services: Room & Board Miscellaneous Care	20% coinsurance	\$0	\$0
Emergency Room/Urgent Care	20% coinsurance	\$35 per visit	\$5 per visit
Outpatient Services: Primary Care Visit Surgery Chemotherapy/Radiation Physical, Speech and Occupational Therapies	20% coinsurance	\$0	\$5 per procedure
Diagnostic Lab & X-Ray	20% coinsurance	\$0	\$0
Prescription Drug Provider	OptumRx	Anthem	Kaiser
Prescription Drug Copay	\$10 Copay (OptumRx authorized pharmacies only)	\$5 generic & brand (In-Network provider)	\$5 generic & brand for 1-100 days
Chemical Dependency Services: Inpatient Outpatient	Not Covered	\$0	\$0 \$5 individual p/visit
Special Services: Ambulance (per transport) Skilled Nursing Facility Durable Medical equipment	20% coinsurance	\$0	\$0
Mental Health: Inpatient services Outpatient services	20% coinsurance	\$0	\$0 \$5 individual p/visit
Supplemental Accident/DME	20% coinsurance	\$0	\$0

ANTHEM BLUE CROSS PPO BENEFIT PLAN DESCRIPTIONS

This section provides a summary of the key provisions of the Fund's Self-Insured Medical Plan, which is only available for "Early Retirees," (meaning retirees who are under 65 and therefore not yet eligible for Medicare). Benefits provided under the Anthem Blue Cross HMO and Kaiser HMO options are described in each HMO's respective *Explanation of Coverage*, which will be provided along with copies of this SPD to HMO enrollees.

How Does the Anthem Blue Cross PPO Medical Plan Work?

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/or family medical deductible?
- 2) Have you reached your annual out-of-pocket maximum (if applicable)? and
- 3) For some benefits, have you used a PPO Provider, or a Non-PPO Provider?

How Are Benefits Determined?

As shown in the Benefits Summary on page 10, there are a few types of payment provisions you should be aware of when determining how much the 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 pays anything. 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 Anthem Blue Cross PPO deductible is \$300 per individual.

You can "carry over" any covered charges applied toward your deductible in the last ninety (90) days of a calendar year to satisfy the deductible for the following calendar year.

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

- Charges for services or treatments which are not covered by the Plan; and/or
- Amounts in excess of what the Plan determines to be 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 non-

PPO providers (also called 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 have to pay toward your covered benefits each calendar year.

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

- Deductibles;
- Charges for services or treatments which are 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”) are **not** subject to your annual out-of-pocket maximum.

- **Choosing a PPO or Non-PPO Provider**

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 80% for all facility charges and services and these services are 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.

When you use a hospital, doctor or other provider who is **not** an Anthem Blue Cross PPO provider, the Plan will pay 80% of what it determines to be Usual, Customary and Reasonable (“UCR”) charges which may be lower than what the Non-PPO provider charges for that service. Your 20% coinsurance of the UCR amount will count towards your deductible. However, any amount that the Plan determines exceeded UCR will:

- Be payable in full by you rather than the Plan;
- Not count toward satisfaction of your deductible;
- Not count toward satisfaction of your Out-of-Pocket maximum; and
- Not count toward your Lifetime Maximum.

- **Lifetime Maximum Benefit**

This is the maximum dollar amount that the Plan will pay for a Retiree or dependent over the course of his or her life. The Lifetime Maximum Benefit payable under the Anthem Blue Cross PPO option is \$1 million. The HMO options have no lifetime maximum.

How to Find an Anthem PPO Doctor or Hospital:

The list of PPO hospitals and doctors is subject to change. To find a Doctor or Hospital in the Anthem Blue Cross PPO Network, or to confirm that a particular hospital or doctor remains on the PPO list, contact Anthem Blue Cross at (800) 274-7767 or consult the Anthem Blue Cross website: www.bluecrossca.com.

How to File Claims:

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 determination timeframes and claims appeal procedures can be found in the "Claims and Appeals Procedures" section beginning on page 41.

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.**

Note: Pre-admission certification is not required for outpatient procedures.

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 Does the Anthem Blue Cross PPO Medical Plan Cover?" below.

For **Emergency Admissions** you must contact Anthem Blue Cross at the number listed above within seventy two (72) 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.

What Does the Anthem Blue Cross PPO Medical Plan Cover?

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 illness (unless the covered service listed is specifically for preventive care).

This information is divided into the following major categories:

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

REMEMBER: For purposes of the Medical Plan benefits the percentage payable – 80% in most cases – assumes that you have not yet reached your annual out-of-pocket maximum. 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 & Reasonable (“UCR”) charges if you use a non-PPO provider.

For a description of the prescription drug benefits available under the Self-Insured Medical Plan see “Anthem Blue Cross PPO Prescription Drug Benefits” on page 19.

At the Doctor's Office:

In addition to the Physician's/Doctor's Office benefits listed in the Benefits Summary on page 10, please note the following about your Doctor's Office benefit:

- Adult Routine Physical Exams or exams required by an Employer are not covered.
- For dependent children the Plan pays 100% of covered charges after the deductible is satisfied for routine physical exams, immunizations and lab services in connection with physical exams.

- OB-GYN Exams and Pap Smears: The Plan pays 80% of covered charges after the deductible; limited to one routine exam and one Pap smear test for cervical cancer per year.
- Outpatient X-ray and Lab Services: The Plan pays 80% of covered charges after the deductible.

At the Hospital:

In addition to the Hospital benefits listed in the Benefits Summary on page 10, please note the following about your Hospital benefit:

- 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.
- For Convalescent Hospitals, room and board is covered 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.

Surgery:

The Plan covers elective and emergency surgery. For non-emergency surgery, pre-admission certification (as described on page 13) is required.

Maternity Services:

Office Visits: The Plan pays 80% of covered facility charges after the deductible.

Hospital Services: The Plan pays 80% of covered charges after the deductible.

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.

Mental Health Services:

The Plan pays 80% of the PPO Rate for In-Network benefits and 80% of UCR for Out-of-Network benefits.

Other Frequently Utilized Medical Services:

For your convenience, the following lists 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. Unless otherwise noted, all benefits below are subject to the deductible.

- **Allergy Injections** – Plan pays 80%.
- **Ambulance** – Plan pays 80% for covered expenses 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/Radiation** – Plan pays 80% for covered expenses.
- **Chiropractic Care** – Plan pays 80% for covered expenses.
- **Durable Medical Equipment** – Plan pays 80% for covered expenses. Includes the rental (up to the purchase price) or purchase of equipment or FDA-approved devices (at the Plan's discretion) that are medically necessary to aid in a covered person's recovery, mobility and/or the support of life.
- **Home Health Care** – Plan pays 80% for covered expenses. Covered 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. (Note: There is no coverage for custodial care.)
- **Hospice Care** – Plan pays 80% of covered expenses. Will cover up to thirty (30) days of inpatient care provided in a hospice facility or outpatient care provided at the patient's home. There is a \$1,500 maximum on outpatient care provided in the home.
- **Hospice Counseling** – Covered up to \$500 per family, as is bereavement counseling, up to \$100 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.
- **Mammograms** – Plan pays 80% for routine mammograms 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 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.

- **Organ Transplants** – Including coverage of the medically necessary care related to the donor (regardless of whether the donor is a Plan participant or covered dependent).
- **Osteoporosis Treatment** – Covered for all FDA-approved treatment, including bone mass measurement technologies, as deemed medically necessary by a doctor.
- **Physical or Occupational Therapy** – Plan pays 80% for covered expenses 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 a Licensed Practical Nurse (“L.P.N.”).
- **Prostate Specific Antigen (“PSA”) Testing** – One per year, unless medically necessary.
- **Prosthetics (External)** – Covered for non-dental use, such as artificial limbs or eyes. Replacement of such devices will be covered only if required by a physical change, such as the growth of a child, or as ordered by the attending doctor in connection with a mastectomy.
- **Radiation Therapy** – Plan pays 80% for covered expenses.
- **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. The first \$100 is covered at 100% and is not subject to the deductible. The remaining charges are covered at 80% and are subject to the deductible.
- **Skilled Nursing Facility** – Coverage for up to one hundred (100) days per calendar year provided while the individual is confined following an illness, injury or hospitalization; includes room and board, and other eligible expenses.

What the Anthem PPO Medical Plan Does Not Cover:

The services listed below are not covered by this Medical Plan.

- Any medical treatment, hospital confinement or any portion of medical treatment or a hospital confinement that is not medically necessary.
- Charges in excess of what the Plan determines to be Usual, Customary and Reasonable (“UCR”).
- Custodial care.
- 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:
 - By the federal Food and Drug Administration (“FDA”), the American Medical Association (“AMA”), the AMA’s Diagnostic and Therapeutic Technology

Assessment (“DATTA”) program, or the Office of Medical Application of Research of the National Institute of Health Office of Technology Transfer (“OTT”); or

- 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.
- Charges incurred for surgery to the eye to correct a refractive error, such as radial keratotomy, or 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.
- Charges incurred in connection with treatment that is cosmetic, other than: reconstructive surgery to restore tissue damaged by injury or illness, including surgery to one or both breasts to reestablish symmetry following a mastectomy; or treatment of a child to correct a congenital disease or anomaly, including an oral defect.
- 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.
- Charges which a covered person is not legally obliged to pay; or treatment which he or she obtains, or is entitled to obtain, under any plan or program without charge. This will include charges for treatment which are provided or paid for by the federal government at a Veteran’s Administration facility for: (1) injury or illness related to a covered person’s military service, or (2) the covered person, or his or her dependents, if the covered person retired from the armed services.
- Charges incurred as a result of an act of war, whether declared or not, or any related act; charges as a result of participation in a riot or civil disorder.
- Charges incurred as a result of: an injury which arises out of or in the course of any employment with any employer, or 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.
- Charges arising out of the pregnancy of a dependent child (other than charges related to complications of pregnancy).
- Drugs or medicines, except while confined to a hospital or that must be administered by a doctor in a clinical setting.
- Hearing aids or eyeglasses.
- Dental services and supplies, unless the expense is necessary for repair or alleviation of damage to natural teeth resulting from an accident.

- 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.
- Treatment of any illness or injury if you are not under the regular care of a doctor.
- Elective abortion, except where the life of the mother is in danger if the procedure is not performed.
- Temporomandibular Joint (“TMJ”) Dysfunction – Treatment for TMJ or any other treatment of the face, neck or head for non-cosmetic purposes is not covered unless the procedure treats a condition caused by congenital deformity, injury or illness; charges for intraoral prosthetic devices are excluded.
- Charges relating to change of sex surgery or any complication resulting there from.

ANTHEM BLUE CROSS PPO PRESCRIPTION DRUG BENEFITS

If you are enrolled in the Anthem Blue Cross PPO option, you are eligible for prescription drug benefits administered by prescription benefits manager, OptumRx, described below. The Plan pays benefits for drugs that have been prescribed as a result of illness, an accidental injury, or pregnancy. Prescription drug benefits are available through a retail pharmacy and through mail order.

Mail Order Refills Required for Maintenance Medications

You are **required to fill your maintenance medications through OptumRx Mail Service Home Delivery.**

Maintenance medications are typically those drugs taken on a regular basis for chronic or long-term conditions, for example: diabetes, high blood pressure (hypertension), cholesterol, and asthma. Non-maintenance medications are those medications used to treat short-term conditions and you may continue to purchase them at a retail pharmacy.

How Do I Use the OptumRx Mail Order Program?

Prescriptions for a supply of maintenance medications of up to one hundred (100) days or more can be obtained through the mail order program.

To obtain drugs through the mail order program, your doctor can provide scripts via:

- E-script or electronic submission
- Fax (800) 491-7997
- Phone (800) 791-7658)

Paper scripts are not required unless the medication calls for it. For example; **CII controlled medications and other drugs will require that a hard copy be mailed in.**

Print the New Prescription Mail-in Order form located at www.optumrx.com or contact Customer Service Mail Order Pharmacy for assistance at (800) 791-7658. Complete the required

information on the form and enclose it with your doctor's prescription in a postage-paid envelope.

If you do not move your maintenance medication prescriptions to Mail Service you may face an increased cost (up to 100%), which will be applied to the next fill at retail.

How Do I Find a Participating OptumRx Retail Pharmacy?

There are two ways to quickly and easily find a retail pharmacy near you:

- Use the Locate a Pharmacy tool at www.optumrx.com;
- Call the toll-free member number (800) 797-9791 which is also listed on the back of your ID card, or (866) 328-2005.

What are my OptumRx Pharmacy Benefit Copays?

- \$10 copay up to 30-day medication supply at participating retail pharmacies (except for maintenance medications, discussed above).
- \$10 copay up to 90-day medication supply delivered to your home.

What Is the Difference Between Brand-Name and Generic Medications?

Generic medications contain the same active ingredients (what makes the medication work) as brand-name medication, 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.

How do I Request a Prior Authorization?

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 OptumRx Customer Service at (800) 711-4555. A Customer Service Advocate will work with your doctor's office to get the information for a prior authorization review.

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. Specialty medications are typically prescribed for complex chronic conditions such as multiple sclerosis and rheumatoid arthritis, rare diseases such as hemophilia or pulmonary arterial hypertension, and 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 the requirements below, contact OptumRx Specialty Pharmacy at (866) 218-5445.

If you are prescribed an Injectable or Specialty drug your doctor must call OptumRx toll-free at (866) 218-5445. OptumRx 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. OptumRx 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, OptumRx may suggest alternatives to the Specialty drug.

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;
- Compounded dermatological preparations, including ointments and lotions prepared by a pharmacist under a doctor's prescription;
- 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; and
- Elixir terpin hydrate, epinephrine, ephedrine sulfate and ferrous sulfate.

Birth Control Pills:

The Plan covers birth control pills for family planning at a participating pharmacy or through the mail order program.

What the Prescription Drug Program Does Not Cover:

For the most current list of drugs covered (also known as a "formulary"), refer to www.optumrx.com or call (800) 797-9791.

HMO MEDICAL PLAN OPTIONS

The Trust offers medical coverage under two Health Maintenance Organizations (“HMOs”) as alternatives to the Self-Insured PPO Medical Plan. They are:

- **Anthem Blue Cross**
- **Kaiser Permanente**

For detailed information about the specific benefits available from either HMO, please refer to your HMO’s Explanation of Coverage (“EOC”).

How Do HMOs Work?

HMO’s emphasize preventative care, while also offering comprehensive medical coverage. To receive medical care, you and your dependents must use your HMO’s doctors and facilities.

- Anthem Blue Cross will require you to designate a Primary Care Physician (“PCP”) from a list of its approved physicians. Your PCP will coordinate all of the care you receive through the HMO.
- Kaiser Permanente is a “staff model” HMO and you may not be required to use a PCP. However, you must obtain all your care at Kaiser facilities.

Other Features of the HMOs Include:

- No annual deductibles. The HMOs cover most services (but HMO coverage is subject to different annual out-of-pocket maximums – see Benefits Summary chart on page 10); and
- No claim forms to file (in most instances).

What are the Payment Provisions?

The HMOs generally pay 100% of the cost of most covered services. Refer to the HMO EOC you received as an HMO participant for additional details.

What are my Prescription Drug Benefits?

If you are enrolled in the Anthem Blue Cross HMO or Kaiser HMO option, your prescription drug coverage is through your HMO provider and your prescription coverage is described in your HMO’s EOC.

What Do the HMO Plans Cover?

Many of the services covered under the HMOs have been summarized in the Benefits Summary chart on page 10. This list is not intended to be exhaustive and you should refer any questions to the HMO’s EOC or to the HMO directly. EOC’s are also available from the Administrator’s Office.

What Do the HMO Plans Not Cover?

See the HMO's EOC for the list of applicable exclusions. However, it is important to remember that, except in emergencies that occur outside your HMO's 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 EOC.

BENEFITS SUMMARY FOR MEDICARE-ELIGIBLE RETIREES

This section provides a summary of the key provisions of the Fund’s Medicare Medical Plan options. Benefits provided under the **Kaiser Senior Advantage HMO** and **TeamSTAR/Teamster Plus** options are described in the Explanation of Coverage (“EOC”), which will be provided along with copies of this SPD to enrollees.

Both Kaiser Senior Advantage HMO and TeamSTAR/Teamster Plus are insurance plans designed to supplement your Medicare coverage. **In order to be eligible for these plans you must be enrolled in Medicare Parts A and B.**

Medicare Eligible Retirees (Age 65 and Older)		
Major Features	<u>Kaiser Senior Advantage HMO</u>	<u>TeamSTAR (Medical) and Teamster Plus (Prescription Drugs)</u>
Providers	Must use Kaiser providers	Must use a doctor who accepts Medicare
Annual Deductible	None	None
Annual Out-of-Pocket Maximum	One person: \$1,500 Two or more persons: \$3,000	No Out-of Pocket Maximum
Lifetime Maximum	None	None
Hospitalization	No copay	No copay
Diagnostic X-Ray and Laboratory	No copay	No copay
Doctor Office Visits	\$5 per visit	No copay
Surgery	Outpatient or Inpatient: No copay	Outpatient or Inpatient: No copay
Pregnancy	Prenatal office visits: \$5 per visit Inpatient care: No copay	Prenatal office visits: No copay Inpatient care: No copay
Home Health Care	No copay	No copay
Skilled Nursing Facility	No copay (up to 100 days maximum per benefit period)	No copay (up to 100 consecutive calendar days)
Hospice Care	No copay	No copay
Preventive Care	Preventative care: \$5 per visit Immunizations: \$5 per visit Annual GYN: \$5 per visit Primary care visits: \$5 per visit	Preventative care: No copay Immunizations: No copay Annual GYN: No copay Primary care visits: No copay

Medicare Eligible Retirees (Age 65 and Older)		
Major Features	Kaiser Senior Advantage HMO	TeamSTAR (Medical) and Teamster Plus (Prescription Drugs)
Emergency Room	\$5 per visit	No copay
Prescription Drug	\$5 copay for 1 to 100 days on generic and brand name drugs; must use Kaiser Pharmacies	\$2 copay generic for 30-day supply \$6 copay generic for 90-day supply Prescriptions managed by Teamster Plus
Mental Health	<u>Outpatient:</u> \$5 per individual visit; \$2 per group visit <u>Inpatient:</u> No copay	<u>Outpatient:</u> No copay <u>Inpatient:</u> No copay
Substance Abuse	<u>Outpatient:</u> \$5 per individual visit; \$2 per group visit <u>Inpatient:</u> No copay	<u>Outpatient:</u> No copay <u>Inpatient:</u> No copay

Medicare-Eligible Retirees Benefit Plan Description

When you become eligible for Medicare, you need to choose to assign your Medicare benefits to Kaiser Senior Advantage or TeamSTAR/Teamster Plus. **If you do not do this your coverage will be terminated sixty (60) days after the date you became Medicare-eligible, which is usually the first day of the month in which you turn 65. To be enrolled for coverage under this plan you must sign up for Medicare Parts A and B.**

- **Out-of-Pocket Maximum**

The out-of-pocket maximum is the maximum amount (in addition to the deductible) you have to pay toward your covered benefits each calendar year.

KAISER SENIOR ADVANTAGE HMO OPTION

How Does the Kaiser Senior Advantage (HMO) Work?

Kaiser Senior Advantage is designed to supplement your Medicare coverage. Kaiser emphasizes preventative care, while also offering comprehensive medical coverage. To receive medical care, you and your dependents must use Kaiser doctors and facilities.

Other Features of the Kaiser Senior Advantage Plan Include:

- No annual deductibles;
- Kaiser covers most services; and
- No claim forms to file (in most instances).

What Are the Payment Provisions?

Kaiser generally pays 100% of the cost of most covered services. Refer to the Kaiser Senior Advantage Explanation of Coverage (“EOC”) you received with this SPD (or ask the Administration Office for a copy) for additional details.

What Does the HMO Plan Cover?

Many of the services covered under Kaiser have been summarized in the chart found on page 25. That chart is not intended to be exhaustive and any questions should be referred to the Kaiser Senior Advantage EOC or to the HMO directly. EOCs are also available at the Administration Office. Prescription drugs are provided through Kaiser.

What Is Not Covered By the HMO?

See the Kaiser Senior Advantage EOC for the list of applicable exclusions. However, it is important to remember that, except in emergencies that occur outside Kaiser’s service area, you must receive all of your care through Kaiser to be eligible for benefits. If you have any questions about your Kaiser coverage, contact Kaiser directly.

TEAMSTAR/TEAMSTER PLUS MEDICARE OPTION

How Do the TeamSTAR and Teamster Plus Medicare Plans Work?

TeamSTAR is health insurance designed to supplement Medicare sponsored by the International Brotherhood of Teamsters for Retirees and their spouses or surviving spouses age 65 and over. It will pay in addition to charges that Medicare approves.

- Call Toll Free (800) 808-3239
- Website: www.teamstar.com

What Are the Payment Provisions?

You must go to a provider who accepts Medicare. If you visit a provider that does not accept Medicare, you could be liable for the entire bill and responsible for filing the claims manually with Medicare.

Teamster Plus Medicare Part D Prescription Drug Program (PDP) (“Teamster Plus”) covers costs for drugs that are available only by prescription, approved by the FDA, used and sold in the United States for a medically-accepted condition, and are on its formulary.

Which Drugs Are Covered by Teamster Plus?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on the Teamster Plus website (www.teamsterplus.com). Or, call toll free (866) 412-7445 and request a copy of the formulary.

Hours of Operation: You can call 7 days a week from 8:00 am to 8:00 pm in your local time zone.

How Will I Determine My Drug Costs?

The Teamster Plus plan groups each medication into one of four “tiers.” You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached. The benefit stages that occur after you meet your deductible are the following: Initial Coverage, Coverage Gap and Catastrophic Coverage (see next page for an explanation).

Retail pharmacies with Union Preferred cost-sharing will fill certain Preferred Generic drugs (“Low Cost Generics”) at a low copay of \$2 for a one month supply. Deductibles do not apply to certain Preferred Generic drugs filled at Union Preferred retail pharmacies. You can view or download the list of Low Cost Generics and retail pharmacies with Union Preferred cost-sharing by scrolling down to “Our Plans” at <http://www.teamstarpard.com>.

What Are the Prescription Drug Benefit Stages?

- **Initial Coverage Stage:** You pay the following until your total yearly drug costs reach \$3,310 (for 2016). Total yearly drug costs are the total drug costs paid by both you and

the Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Union Preferred Cost-Sharing*

Tier	One-Month Supply Retail	Three-Month Supply Retail
Low-Cost Generics	\$2	\$6

Standard Cost-Sharing

Tier	One-Month Supply Retail	Three-Month Supply Retail	Three-Month Supply Mail
1	\$5	\$10	\$10
2	\$10	\$20	\$20
3	\$20	\$40	\$40
4	\$20	\$40	\$40

* Note: If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

- **Coverage Gap:** Most Medicare drug plans have a coverage gap (also called the “donut hole”) that begins after the total yearly drug cost reaches \$3,310 (for 2016). This Teamster Plus drug plan does not have a coverage gap or “donut hole.” After you enter the coverage gap stage, you will continue to pay the same cost-sharing shown for the Initial Coverage stage above.
- **Catastrophic Coverage Stage:** After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850 (for 2016), you pay the greater of:
 - 5% of the cost; or
 - \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs (for 2016).

However, in no event will you pay more than the cost-sharing shown for the Initial Coverage Stage.

Which Pharmacies Can I Use?

Teamster Plus has a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of the network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see the plan’s pharmacy directory at the website [//www.teamsterplus.com](http://www.teamsterplus.com), or call (866) 412-7445 and request a copy of the pharmacy directory.

IMPORTANT TELEPHONE NUMBERS AND RESOURCES

Have Questions or Need Information?	Call	Telephone Number /Website	For
Eligibility for Benefits You & Your Dependents Enrollment and Application Forms	Health & Welfare office Local 70	www.corcoranadmin.com/ebdd 510-636-0381	All Retirees
Anthem Blue Cross PPO Medical Plan (Insured)	Administration Office	925-954-1439 855-263-7242	Non- Medicare Retirees
Prescription Drug Coverage <i>(with PPO plan above)</i> OptumRx Retail Pharmacy Mail Order Injectables & Specialty Drugs	OptumRx Member Services Dedicated Trust Phone OptumRx Mail Delivery Optum Specialty Pharmacy	www.optumrx.com 800-797-9791 866-328-2005 800-791-7658 866-218-5445	Non- Medicare Retirees
Utilization Review Program/ Pre-Admission Certification	Anthem Blue Cross	800-274-7767	Non- Medicare Retirees
Anthem Blue Cross HMO (HMO & Prescription Drugs)	Anthem Blue Cross	www.anthem.com/ca 800-888-8288	Non- Medicare Retirees
Kaiser HMO (HMO & Prescription Drugs)	Kaiser Foundation Health Plan	www.kp.org 800-464-4000	Non- Medicare Retirees
Kaiser Senior Advantage (HMO & Prescription Drugs)	Kaiser Foundation Health Plan	www.kp.org 800-464-4000	Medicare- Eligible Retirees
TeamSTAR Medicare Plan	TeamSTAR	www.teamstar.com 800-808-3239	Medicare- Eligible Retirees
Teamster Plus Medicare Plan Prescription Drug coverage <i>(with TeamSTAR plan above)</i>	Teamster Plus Claims 24/7 Customer Service	www.teamsterplus.com www.teamstarpard.com 855-828-8951 866-412-7445	Medicare- Eligible Retirees

OPEN ENROLLMENT

You will have the opportunity to change your medical option during the Plan's annual Open Enrollment. Open Enrollment is traditionally held during July and any changes become effective August 1; however 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 option will be continued for the next benefit year. This is subject to one exception: Under state law you must live or work within fifteen (15) miles or thirty (30) minutes of an HMO hospital and doctor. If you are enrolled in the Kaiser or Anthem Blue Cross HMO and move to an area over 30 minutes, or 15 miles from the nearest Kaiser facility or Anthem Blue Cross HMO contract hospital or doctor, you can change your medical option outside of Open Enrollment.

DEFINITIONS OF IMPORTANT WORDS

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, Inc., should be used for purposes of any oral or written communications with the Trust Fund.

Chris Corcoran, Plan Manager
Corcoran Administrators, Inc.
P.O. Box 5030
Walnut Creek, CA 94596
Phone: (855) 263-7242

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.

Complications of Pregnancy: All physical effects suffered which have been directly caused by your pregnancy but which would not, from a medical viewpoint, be considered the effects of a normal pregnancy. These include, but are not limited to, acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which terminated, cesarean section, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, and related medical and surgical conditions.

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.

Cosmetic: Surgery or other treatment performed primarily to alter and reshape normal body structures in order to improve a covered person's looks.

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.

Custodial Care: Treatment, services or confinement, intended primarily to help the patient with daily living activities. Custodial care includes personal care such as 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, homemaking, such as preparing meals or special diets, moving the patient, acting as a companion or sitter, and supervising medication which can usually be self-administered.

Dependent:

- Your legal spouse or domestic partner; and
- Your unmarried children, up to age eighteen (18), who depend primarily on you for support, including stepchildren, legally adopted children, children placed with you for adoption, or children for whom you have been appointed legal guardian by court order; your unmarried children, up to age twenty six (26) who are full-time students in high school or an accredited college or university, and who depend primarily on you for support.

No one other than those described above qualify as dependents.

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: Equipment that is:

- Prescribed by an attending doctor;
- Designated for prolonged use;
- Not used primarily for non-medical purposes or used by other family members; and
- Not specifically excluded by the Plan.

Emergency: The sudden unexpected onset of symptoms or a medical condition that is severe enough to require immediate medical attention without which the person’s health would be in jeopardy, would have serious medical consequences, receive damage to bodily functions, or have severe and permanent consequences to any bodily organ or part.

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: 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; and
- 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.

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; and
- 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: Refers to any services that a hospital, related institution, home health care agency, hospice or other licensed facility provides under a hospice care program.

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.

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.

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

Medically Necessary, Medical Necessity: To be considered medically necessary, the treatment must be ordered by a doctor to diagnose or treat an injury or illness and is:

- 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;
- Appropriate for the symptoms and consistent with the diagnosis;
- 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 practice in the United States;
- 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;
- 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; and
- Not custodial care.

Mental Health Condition, Mental Disorder: 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, or physical manifestations of such disorder.

Any condition meeting this definition is a mental or nervous illness or disorder, no matter what the cause of the condition might be, from physical, mental, organic, or through environmental cause, or any combination. Any condition meeting this definition is included in it, regardless of whether it produces physical or emotional symptoms.

Medicare: The medical benefits program provided by Title XVIII of the federal Social Security Act, as amended.

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.

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.

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.

Usual, Customary and Reasonable (“UCR”): A charge for treatment, which is the lesser of the following:

- The usual charge made by the provider for that treatment; or
- The prevailing charge made by other providers of similar professional standing within the same or a similar geographic area for that treatment.

If the usual or prevailing charge cannot be determined, the Plan will determine what is a reasonable charge, taking into account the following:

- Any unusual complications of the injury or illness;
- The complexity and degree of professional skill required; and
- Other factors deemed pertinent by the Plan.

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 retiree/Plan participant.

YOUR RIGHTS AND ADDITIONAL INFORMATION

This section provides you with important information about the East Bay Drayage Drivers Security Fund.

Plan Name and Address:

East Bay Drayage Drivers Security Fund
Chris Corcoran, Plan Manager
Corcoran Administrators, Inc.
P.O. Box 5030
Walnut Creek, CA 94596
Phone: (855) 263-7242

Plan EIN: The Plan's Employer Identification Number ("EIN") for IRS purposes is 94-6073020.

Type of Plan/Collective Bargaining Agreements:

The Plan is a Retiree medical plan. The Plan is funded and maintained through monthly contributions from participating Employers paid on behalf of eligible Employees and their covered dependents and Retiree self-payments pursuant to a collective bargaining agreement and the terms of the Plan. 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.

Plan Administrator:

The Plan is administered by the Board of Trustees of the East Bay Drayage Drivers Security Fund, which contracts for administrative services with Corcoran Administrators, Inc., a company that can be reached at the address listed above.

Plan Trustees:

As of the date of the printing of this SPD in 2016, the Trustees of the East Bay Drayage Drivers Security Fund are:

Employer Trustees

Richard Murphy
c/o Fund Administration Office
PO Box 5030
Walnut Creek, CA 94596

Jack Isola
c/o Fund Administration Office
PO Box 5030
Walnut Creek, CA 94596

Richard Valle
Tri-CED
33377 Western Avenue
Union City, CA 94587

Mike Carnefix
UPS
8475 Pardee Road
Oakland, CA 94621

Union Trustees

Marty Frates
Secretary-Treasurer
Teamsters Local 70
400 Roland Way
Oakland, CA 94621

Dominic Chiovare
President
Teamsters Local 70
400 Roland Way
Oakland, CA 94621

Mark Hawkins
Business Agent
Teamsters Local 70
400 Roland Way
Oakland, CA 94621

Felix Martinez
Business Agent
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:

Chris Corcoran, Plan Manager
Corcoran Administrators, Inc.
P.O. Box 5030
Walnut Creek, CA 94596
Mailing address:
3313 Vincent Rd. #216
Pleasant Hill, CA 94523

Legal process may also be directed to any member of the Board of Trustees.

Plan Year: The Plan Year is November 1 to October 31.

Plan Funding and Contributions:

The Plan is funded by monthly contributions from participating employers paid on behalf of eligible employees and their eligible dependents, and self-payments by retirees.

The employer and retiree contributions are 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.

Plan assets are held in trust and benefits are funded through the Trust Fund.

Medical coverage benefits are funded directly by the Trust Fund. HMO benefits are insured through the respective HMO plan. All other benefits are funded directly by the Trust Fund, although the Fund may use a third party, such as OptumRx (for prescription drugs). Plan assets are held in trust for the sole purpose of funding Plan benefits and paying the costs of Plan and Trust administration.

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, and 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.

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. 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 for retired employees 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 Retiree Plan, including benefits 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 retirees may be changed or eliminated at any time by action of the Trustees or by action of the participating employers and the Union. A change or termination of benefits will apply to individuals who have already retired as well as to future retirees.

There is no vested right to receive benefits under this Plan.

CLAIMS AND APPEAL PROCEDURES

You and your dependents must file an application or claim for benefits by completing the necessary forms (unless otherwise indicated). Claim forms are available from the Administrator or from Local 70.

Information about the Claims Administrator for each benefit provided by the Plan, including telephone number, can be found on page 29.

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 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 Medical Benefits:

To file claims for any of the Plan's medical benefits, follow the procedures as described in this section. The claims procedure you follow will depend on whether your claim for benefits is a pre-service claim, an urgent care claim, a post-service claim, or a concurrent care claim. The description of each kind of claim and the process for filing each claim is described below.

Filing an Initial Pre-Service Claim:

A "Pre-Service Claim" is any claim for services not yet performed and which are not for urgent or concurrent care. 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:

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.

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.

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.

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.

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.

Appealing a Concurrent Care Claim:

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.

Initial Denial of a Claim:

If your claim is denied in whole or in part, you will receive written notice of an adverse decision which includes (1) the specific reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) if applicable, a description of any additional information required and why that information is required to perfect your claim; (4) a statement concerning your right to bring a civil action under ERISA following an adverse decision on appeal of the denial of your claim; and (5) the Plan's appeal procedures, including applicable time limits and your right to submit written comments, documents, and other information relating to the claim and request in writing to review or receive copies, free of charge, of Plan documents, records, or other relevant and non-privileged information.

The claims denial will also notify you of any internal rule, guideline, or similar criterion relied on by the Administration Office in its denial of your claim and that, upon request, you will be provided with a copy, free of charge, of such rule, guideline, or similar criterion. If your claim is denied based on a medical necessity or the use of experimental or investigational treatment or other similar exclusion or limit, you will be provided, free of charge at your request, an explanation of how that exclusion or limit and any clinical judgments apply to your claim.

The time period applicable to appeal of a denied claim depends on whether it is a "pre-service," "post-service," or "concurrent care" claim. See the discussion of "pre, post [and] concurrent" care claims above to determine how soon you must file an appeal and how long the Board of Trustees have to consider your appeal.

Denial of a Claim on Appeal:

If your claim is denied on appeal, you will receive written notice stating the information described above under the heading *Initial Denial of a Claim*. 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.

If your final appeal is ultimately denied in whole or in part you have the right to file a lawsuit under ERISA (see page 49). Any such lawsuit concerning an appeal denied in whole or part on or after October 1, 2011 must be filed within one (1) year from the date of the Fund's notice of denial of the appeal or other final adverse determination, and also within any statute of limitations which may apply.

COORDINATION OF BENEFITS

If you or your dependent is entitled to any benefits under another medical plan, the Coordination of Benefits (“COB”) provision ensures that the total amount of benefits paid will not be more than 100% of the expense you incurred.

In no event will the amount of benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved. If you have dual coverage under this Plan (because you are eligible as an individual and as a dependent or as a dependent of two insured individuals), the total amount of benefits payable because of your dual coverage cannot exceed the total amount of expense covered by the Plan.

When a claim is made, the *primary* plan pays its benefits without regard to any other plan. Then, the *secondary* plan adjusts its benefits so that the total benefit will not be greater than the allowable expense. When determining whether this Plan or another group plan is the primary payer, the following will apply:

- The plan that covers you or your dependent as a retiree or active employee pays benefits before the plan that covers you or your dependent as a dependent.
- The plan that covers you as a retiree or dependent will pay benefits before the plan that covers you or your dependent under COBRA continuation coverage.
- If you are eligible for Medicare, Medicare pays first and the plan pays second. Remember, you and/or your dependents must be enrolled in Medicare if eligible.
- In the case of a 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 that case, the other plan shall determine the order of benefit payments. If the other plan does not have a coordination of benefits provision then this plan pays first.
- If you are separated or divorced, the order of payment for your dependent child is:
 - The plan of the natural parent with custody will pay benefits first;
 - The plan of the stepparent with custody pays benefits before the plan of a natural parent without custody;
 - The plan of the natural parent without custody then pays.

Note that the plan of the parent determined by a Qualified Medical Child Support Order (“QMCSO,” see “Definitions” on page 35) to be financially responsible for health care expenses of the child pays first.

If these rules do not decide which plan’s benefits are payable first, the plan that has covered the person for the longest time will be primary.

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.

Right of Reimbursement in Cases of Third Party Liability:

The Trust reserves the right to recover claim payments made under any of its Plans on behalf of an employee or dependent where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse the Trust in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the Trust for the claims it has paid, the Plan will deduct the amount paid from any of your future benefit claims as a set off.

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’s” 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 PLAN WILL PAY CLAIMS FOR EXPENSES INCURRED BECAUSE OF AN ILLNESS OR INJURY FOR WHICH A THIRD PARTY IS (OR MAY BE) RESPONSIBLE. BY SUBMITTING THE CLAIM FOR PAYMENT BY THE PLAN, YOU (OR YOUR DEPENDENT, IF HE OR SHE SUFFERS THE ILLNESS OR INJURY) ARE DEEMED UNDER THE PLAN TO HAVE AGREED TO EACH OF THE FOLLOWING CONDITIONS:

- If you or your dependents sue or recover compensation, reimbursement, damages or any other payment of any kind from the third party for the illness or injury, the Fund has an equitable lien (a “security interest”) on any amount(s) you or your dependents receive or may become entitled to receive from the third party (or the third party’s insurance company) up to the amount of the Plan benefits paid because of the illness or injury. You must advise the third party that this is a condition of the Plan.
- You or your dependents will furnish the Fund with a copy of any complaint you or your dependents file to recover damages from a third party within no more than two days of the date of filing.
- If you or your dependents receive payment(s) of any kind from the third party (or from the third party’s insurance company), you and/or your dependents will promptly reimburse the Fund for any claims paid because of the illness or injury. If you or your

dependents sue or recover payment of any kind from a third party for an illness or injury (whether or not these payments are characterized in any way as compensation for your injuries or for health care claims), the Fund shall have an equitable lien and the right of first reimbursement out of the amount recovered. This Plan is not subject to the “Make Whole Doctrine”: The Fund’s right of first reimbursement shall apply even if the amount you or your dependents receive from the third party is less than your actual loss resulting from the illness or injury.

- This Plan is not subject to the “Common Fund Doctrine” with respect to attorney’s fees and other costs of litigation and assumes no responsibility for any expenses incurred to obtain a settlement, award, remedy, recovery, or payment of any kind from a third party – including legal costs and attorney’s fees. Expenses related to any recovery from a third party shall not reduce the amount due the Fund pursuant to its equitable lien on your recovery.
- If you or your dependents do not sue the third party for the illness or injury, the Fund reserves the right to sue the third party for the amount of Plan benefits paid on your or your dependents’ behalf.
- You and your dependents will help the Fund recover the Plan benefits from the third party by taking reasonable steps to secure payment from the third party and/or assisting the Fund to recover payment from the third party.
- You and your dependents will sign any papers reasonably related to the Fund’s recovery from the third party including but not limited to signing the Fund’s form which memorializes the Fund’s lien claim on your third party recovery.
- You and your dependents will not do anything to interfere with the Fund’s rights to recover Plan benefits from the third party.
- You and your dependents will tell the Fund immediately when you receive payment from a third party in connection with the illness or injury by calling the Administration Office at (855) 263-7242.
- If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.
- 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.

If you or your dependents do not receive payment from a third party to reimburse you for an illness or injury caused by the third party, you do not have to reimburse the Fund for any benefits properly paid to you or your dependents. If you do receive payment from the third party, you do not have to pay the Fund more than the amount the third party paid to you or your dependents.

If you have any questions about how to comply with these third party liability rules, contact the Administrative Office.

Right of Reimbursement in Cases of Payment in Error or Fraud:

In the event you or a dependent receive (1) a benefit payment in excess of the amounts provided for in this Plan, or (2) payment for claims or expenses not covered by this Plan, or (3) payment for benefits based on misrepresentation of the facts or fraud, the erroneous payments shall be repaid by you, your dependent, or the provider of services upon demand by the Trust Fund. If such amounts are not promptly repaid, the Trust Fund reserves the right to deduct the amount erroneously paid from any of your or your dependents' future claims, to file suit, or to take any other action to recover such payments the Board of Trustees deems appropriate.

YOUR LEGAL RIGHTS UNDER FEDERAL LAW

Your Legal Rights under ERISA:

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

As a participant in the Plan, you have certain rights and protections under ERISA. ERISA provides that you, as a participant or beneficiary in each plan, are entitled to:

- Receive information about your plan and benefits;
- Continue group health plan coverage after losing coverage;
- Prudent actions by plan fiduciaries;
- Enforce your rights; and
- Assistance with your questions.

ERISA provides that all participants in an ERISA-subject plan are entitled to:

- Examine, without charge, at the Plan Administrator’s principal office – and at other specified locations such as worksites and union halls – all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration;
- Obtain copies of documents governing the operation of the Plan and other Plan information by writing to the appropriate Plan Administrator (there may be a reasonable charge for the copies);
- Receive a summary of the Plan’s annual financial report (if any) – the Plan Administrator is required by law to furnish each Plan participant with a copy of this summary annual report; and
- Continue health care coverage (either for yourself, or your spouse and/or dependent children) if there is a loss of coverage under the Plan due to a qualifying event, though you or your dependents will have to pay for this coverage.

In addition to creating rights for Plan participants, ERISA imposes obligations on those responsible for the operation of the Plan. The people who operate the Plan (“fiduciaries”) must do so prudently and in the interest of all Plan participants and beneficiaries.

No one – neither your employer nor any other individual – may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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.

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial and you have the right to have the Plan Administrator review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request a copy of the Plan document or the latest annual report from the Plan Administrator and do not receive them within thirty (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 them, unless they were not sent because of reasons beyond the Administrator's control.

If your claim for benefits is denied in whole or in part, and you have been through the Plan's appeals procedure, you may sue in a state or federal court. In addition, if you disagree with the Plan Administrator's decision concerning the qualified status of a Domestic Relations Order or Medical Child Support Order, you may file suit in a federal court. Any such lawsuit must be filed **within one (1) year** of the date of the Plan's notice of denial of your appeal (or other final adverse benefit determination).

Similarly, if you believe that any Plan fiduciary is misusing Plan 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 win, the court may order the person you sued to pay these legal expenses. If you lose, the court may order you to pay the court costs and legal fees (if, for example, it finds your claim is frivolous).

If you have questions about one of the plans, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact 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 also may 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.

Rights under the Mothers and Newborns Protection Act:

Federal law bars group health plans and health insurance issuers from restricting coverage for a hospital stay in connection with childbirth for the mother of a newborn child to less than forty eight (48) hours following a vaginal delivery or less than ninety six (96) hours after a cesarean section. However, federal law does not prohibit the mother or newborn's doctor, after consulting with the mother, from discharging the mother and newborn earlier.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 **("HIPAA")**

Your Health Information and Privacy:

The health benefit options offered under the Plan use health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. The Plan's Privacy Notice is printed here.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective April 14, 2003, the health benefit plan options offered under the Plan will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the applicable federal regulations issued by the Department of Health and Human Services. Specific procedures related to the security of electronically transmitted Protected Health Information ("ePHI") effective April 20, 2005 are also described below.

Privacy Practices Rule:

The Plan has been amended to conform to the "Privacy Rule" described as follows.

Disclosure and Use of Health Information:

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; and
 - 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 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 trustee 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: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and plan design. The Plan also may provide summary health information to the Plan

sponsor so that the Plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

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

- 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; and
- 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.

- **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 record 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 twelve (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 this Notice.** You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this 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.

Contact Person:

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact him/her at:

Privacy Officer - East Bay Drayage Security Drivers Fund
c/o Corcoran Administrators, Inc.
P.O. Box 5030
Walnut Creek, CA 94596
(855) 263-7242

Effective Date: The Plan's privacy policies and procedures became effective April 14, 2003.

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.